# Booval Chiropractic

Today's date: ____________

**Please print clearly, and be thorough. Thank you! Please note this form has two sides.**

First Names: ____________ Family Name: ____________

Address: ____________ Post Code: ____________

Age: ______ Date of Birth: ____________ Marital Status: ____________ Title: ______ No. of Children: ______

Work Tel: ____________ Home Tel: ____________ Mobile: ____________

Occupation: ____________ Are you a: ☐ Private patient ☐ EPC/CDM ☐ DVA ☐ W/Cover

Email: ____________ Date of last Chiropractic Care: ____________

Emergency contact: ____________ Emergency number: ____________

Do you have private health (with extras cover)? ☐ Yes ☐ No If yes, who with? ____________

How did you learn of the Clinic? ____________

**What kind of Chiropractic Care do you prefer? (please tick)**

☐ Relief Care only (this is more likely to be temporary)
☐ Relief and Correction (this tend to improve overall health and to be more permanent)
☐ Preventive/ Wellness Care

**Please list the problems for which you seek help today:**

1: ____________ 3: ____________

2: ____________ 4: ____________

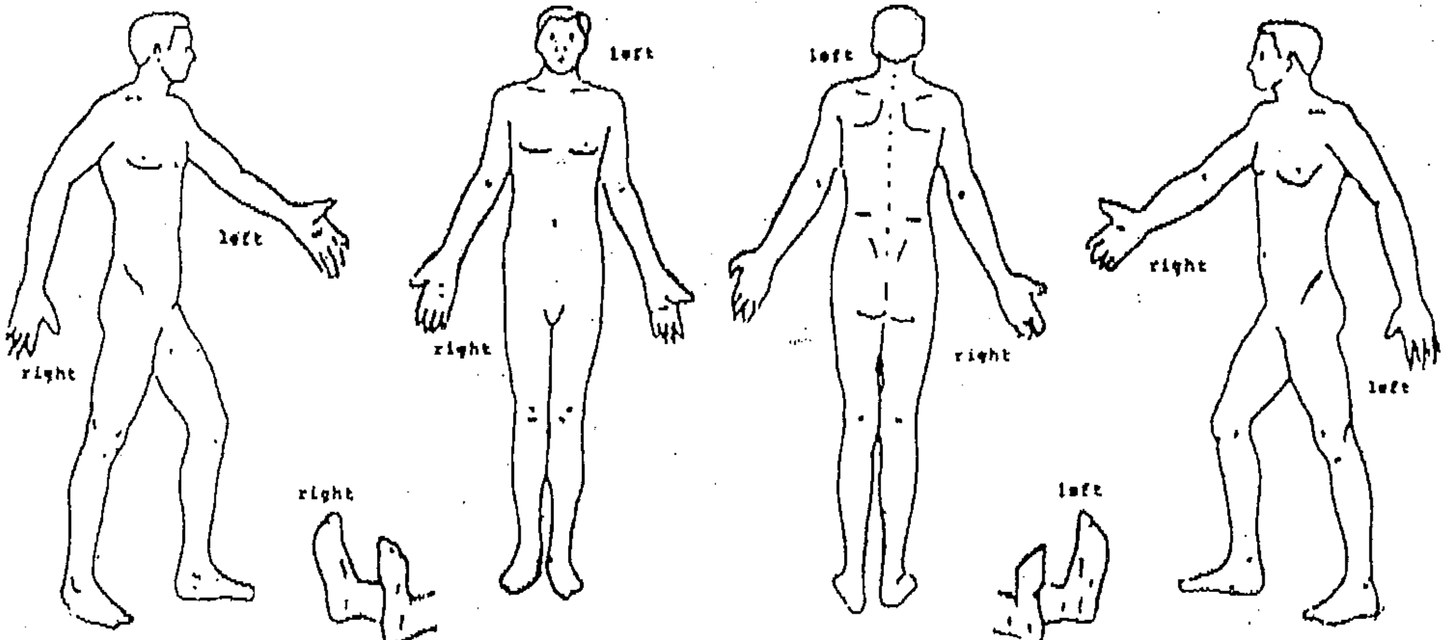
**Pain Severity**

Please make a SINGLE mark through a line at a point showing how bad the pain is now.

Problem 1: No Pain ( ____________ ) Unbearable
Problem 2: No Pain ( ____________ ) Unbearable
Problem 3: No Pain ( ____________ ) Unbearable
Problem 4: No Pain ( ____________ ) Unbearable

**Pain Chart**

Please shade the pain areas, DO NOT use arrows or circles.



List ALL drugs/medicines you take ______________________________

______________________________

List ALL operations (dates, too) ______________________________

List ALL x-rays (dates, too) ______________________________

List ALL accidents (dates, too) ______________________________

**TICK** what you **HAVE NOW**, and **UNDERLINE** what you **HAVE HAD** in the last **FIVE** years.

| | | |
|---|---|---|
| Alcoholism | Dizziness | Ear ache |
| Allergy | Diabetes | Sexually transmitted disease |
| Anxiety/ Depression | Convulsions | Painful sex |
| Arm Pain | Bowel trouble | Gout |
| Arthritis | Tinnitus | Ankle swelling |
| Joints swollen | Digestive difficulties | Menstruation pain |
| Abdominal pain | Spinal curve | Menses irregular |
| Knee pain | Scoliosis | Hot flushes |
| Leg pain | Fever | Breast lumps |
| Chest pain | Fatigue | Vomiting blood |
| Elbow pain | Cancer | Thrombosis |
| Ankle pain | Hoarseness | Low blood pressure |
| Hip pain | Asthma | High blood pressure |
| Foot trouble | Difficulties breathing | Stroke |
| Hand pain | Scarlet fever | Heart disease |
| Headache | Gall bladder trouble | Drug dependence |
| Jaw Pain/ Clicking | Urinating frequently | Epilepsy |
| Low back pain/ Stiffness | Urinating pain | Relationship stress |
| Mid back pain | Swallowing difficulties | Job stress |
| Migraine | Kidney trouble | Other stress |
| Neck pain/ Stiffness | Deafness | Other (please explain) |
| Shoulder pain | Prostate trouble | |

How much do you smoke? ______________ What exercise do you get? ______________

How much alcohol do you consume weekly? ____________ How many alcohol-free days weekly? ____

Do you sleep well? ☐ Yes ☐ No How much coffee/cola do you consume daily? ______________

Do you eat a full breakfast daily? ☐ Yes ☐ No Is your diet good (fresh fruit, vegetables etc. daily?) ☐ Yes ☐ No

Is there anything else we should know about you or your health (please explain) ______________

______________________________

______________________________