Case No:	Date:

Clane Chiropractic

Surname..... Title.....

First Name.....

Address.....

E-mail..... Phone (H).....

Date of Birth..... Marital Status..... Phone (M).....

Number & Age of Children..... Occupation.....

Name of GP..... Surgery.....

Who may we thank for referring you to us?.....

HOW CAN WE HELP YOU?

What brings you in today?.....

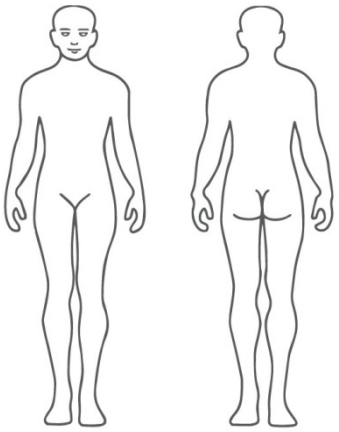
If you are already experiencing a symptom, what is it?.....

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

No symptoms — Intense symptoms

Please circle on the images where you have pain or other symptoms.



What does it feel like? (tick where appropriate)

□ Numbness	□ Sharp
□ Tingling	□ Shooting
□ Stiffness	□ Burning
□ Dull	□ Throbbing
□ Aching	□ Stabbing
□ Cramping	□ Swelling
□ Nagging	□ Other_____

IMPACT OF YOUR SYMPTOMS

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	□	□	□	□	Energy	□	□	□	□
Exercise	□	□	□	□	Attitude	□	□	□	□
Recreation	□	□	□	□	Patience	□	□	□	□
Relationships	□	□	□	□	Productivity	□	□	□	□
Sleep	□	□	□	□	Creativity	□	□	□	□
Self-Care	□	□	□	□	Other_____	□	□	□	□

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

Not Committed — Very Committed

PATIENT WELLNESS ASSESSMENT

On the arrow diagram above:

a) What number do you think represents your health today?_____

(If 2 or more points apply to you, your health is likely represented by this number e.g. If you are experiencing symptoms and taking medication your current health is represented by a 1-3)

b) What number would you like to be (your goal)?_____

c) How long do you think that might take to get to where you have circled? _____

d) What are your health goals?

Immediate_____ (Daily activities/back to work/stop meds)

Short term_____ (Play with kids/return to exercise)

Long term_____ (Run marathon/travel/sport)

e) What things might you need to change to help you reach your health goals?

i)_____ (exercise/smoking/drinking)

ii)_____ (sitting/meditate/diet)

iii)_____(lying on sofa/ sleep)

HEALTH & ILLNESS HISTORY

Please tick the box beside any condition that you have or have had.

□ AIDS/HIV
□ Alcoholism
□ Anxiety
□ Arteriosclerosis
□ Arthritis
□ Asthma/Allergies
□ Back Pain
□ Cardiovascular Issues
□ Cancer
□ Circulation Issues
□ Childhood Illness
□ Depression
□ Diabetes
□ Digestive Issues (Constipation/Diarrhoea/IBS)
□ Elbow/Wrist/Hand Issues
□ Thyroid Issues
□ Foot/Ankle Issues
□ Gout
□ Headaches/Migraines
□ Heart Disease
□ Hepatitis
□ Hip Issues
□ Immune Issues
□ Lymphatic Issues
□ Multiple Sclerosis
□ Neck Pain
□ Reproductive Issues
□ Ringing in Ears
□ Scoliosis
□ Shoulder Issues
□ Stroke
□ TMJ Issues
□ Urinary Issues
□ Osteoporosis
□ Other_____
_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONSENT

- I have read and understand the Chiropractic Awareness Sheet.
- I agree to have my personal and medical records stored electronically in accordance with the Data Protection Act and I understand that you may write to me from time to time.
- Please tick if you do not wish to receive periodic educational information and upcoming offers □.
- I have seen the complaints procedure and I understand that it is available to me at any time.
- I hereby consent to be examined.

Signed…… Date……..

(In the case of a child, or a person of diminished intellectual capacity, parent/guardian to sign)