hastings chiropractic & NATURAL HEALTH

chiropractic ● massage ● natural therapies ● x-ray ● bone density testing

Name: _____ Date: / /

Occupation: _____ Employer: _____

What is the main reason for your visit today? _____

How long have you had this problem for? _____ Have you ever suffered from this before? YES / NO

Is your problem related to any trauma or accident? YES / NO _____

What is your reason for seeking treatment?

- ❑ I only want relief for my pain
- ❑ I would like to correct the problem
- ❑ I would like to avoid the problem returning
- ❑ I would like to improve my health

Please list any other health illnesses/concerns you have:

1. _____
2. _____

Please list the other health practitioners you consult (eg – GP, masseur, specialists, previous chiropractors)

1. GP _____ Location _____
2. _____
3. _____

Please list all medications you are currently taking (including natural remedies such as vitamins):

1. _____
2. _____

Please list all previous major surgeries you have had:

1. _____
2. _____

***HEALTH QUESTIONNAIRE*** *Please tick whichever of the following you have.*

o Headaches/Migraines
o Neck Pain/Stiffness
o Shoulder Pain/Stiffness
o Arm Pain
o Elbow Pain/Stiffness
o Wrist/Hand Problems
o Chest Pain
o Low Back Pain/Stiffness
o Upper Back Pain/Stiffness
o Hip Pain/Stiffness
o Knee Pain/Stiffness
o Leg Pain
o Ankle/Foot Pain/Stiffness
o Numbness
o Pins and Needles
o Muscle Cramps
o Loss of Strength
o Arthritis
o Loss of Co-ordination
o Loss of Balance
o Dizziness
o Nausea/Vomiting
o Visual/Eye Problems
o Rapid Weight Loss
o Heart Problems
o Blood Pressure Problems
o Stroke
o Circulation Problems
o Respiratory Problems
o Gastrointestinal Problems
o Urino-Genital Problems
o Cancer
o Diabetes
o Psychiatric Conditions
o Hepatitis/HIV/AIDS
o Epilepsy
o Varicose Veins
o Joint Replacements
o Pregnancy
o Shingles
o Blood Clots
o Allergies
o PMS Syndrome