KARRINYUP
WELLNESS CENTRE
Chiropractic • Massage • Naturopathy

Chiropractic Adult Health History Form

Welcome to the Karrinyup Wellness Centre

To enhance your health journey with us, we ask that you please fill out the following information. This will aid our Chiropractors in ensuring that your health outcomes are met.

Today's Date:_____ Client ID:_____(office use only)

Title: (Please circle) Mr/Mrs/Ms/Miss/Dr

Full Name:_____ Date of Birth:_____

Address:_____
Street Suburb Post Code

Phone: Home_____ Work_____ Mobile_____

Occupation:_____ Marital Status:_____ Partners Name:_____

Names and ages of Children:_____

Email Address:_____

I wish to receive email newsletters/updates: Yes ☐ No ☐

Who may we thank or how did you hear about this clinic:_____

Were you referred to a particular Chiropractor?_____

Have you ever received chiropractic care: Yes ☐ No ☐

If yes, from whom?_____ When_____

Have you ever had x-rays: Yes ☐ No ☐

When:_____ Region:_____

Are you in a health fund? Yes ☐ No ☐

Name of Fund:_____ Your number (eg 01 or 02)_____

Radiological Consent

I consent to a professional and complete chiropractic examination. I understand that Radiological Examination of the spine and skeletal structure may be deemed necessary as part of my examination. Any proposed imaging procedures will be explained in full. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Is there any chance you may be pregnant? Yes ☐ No ☐ N/A ☐
If yes, how many weeks?_____

Proposed Procedure_____

Sign_____ **Date**_____

Health Profile

During the course of your life's journey you may have encountered many stressors. Whilst some of these stressors may have seemed small, they may have had an accumulating effect on your life, please answer the following questions to the best of your ability.

Childhood Years (birth - 17 years of age)

Describe any complications during your Birth (ie C-Section, forceps):

Did you have any childhood illnesses? Yes ☐ No ☐ If yes, please explain:

Describe any serious falls or injuries as a child:

List any prolonged use of drugs in childhood such as antibiotics:

Did you have any surgery/s Yes ☐ No ☐ If yes, please explain:

Were you involved in any car accidents? Yes ☐ No ☐

Did you suffer any other traumas? (physical or emotional) Yes ☐ No ☐ If yes, please explain:

Did you receive chiropractic care as a child? Yes ☐ No ☐

Adult Years (18 years of age – present)

Did/Do you smoke? Yes ☐ No ☐ How many cigarettes do you smoke per day?

Did/Do you drink alcohol? Yes ☐ No ☐ How many drinks per week do you consume?

Have you had any surgery/s? Yes ☐ No ☐ If yes, please explain:

Were you involved in any car accidents? Yes ☐ No ☐

Have you been in any other accidents? Yes ☐ No ☐ If yes, please explain:

List any broken bones/fractures:

Have you suffered any other traumas? (physical or emotional) Yes ☐ No ☐ If yes, please explain:

Health history

Please mark the following condition that you are currently experiencing or have caused you problems in the past 6 to 12 months:

☐ Neck pain	☐ Stomach upsets	☐ Poor concentration	☐ Heart condition
☐ Stiff neck	☐ Stomach ulcers	☐ Loss of memory	☐ Hypertension
☐ Headaches	☐ Heart burn	☐ Cold sweats	☐ Chest pain
☐ Dizziness	☐ Reflux	☐ Fever	☐ Rapid heart beat
☐ Ears ringing	☐ Bloating/gas	☐ Colds/flu	☐ Stroke
☐ Ear aches	☐ Gall bladder issues	☐ Sleeping problems	☐ Vascular disease
☐ Shoulder pain	☐ Constipation	☐ Fatigue	☐ Asthma
☐ Tingling in arms	☐ Diarrhoea	☐ Irritability	☐ Bronchitis
☐ Numbness in fingers	☐ Weight problems	☐ Tension	☐ Pneumonia
☐ Mid spine pain	☐ Menstrual pain	☐ Anxiety	☐ Thyroid problems
☐ Lower back pain	☐ Thrush	☐ Depression	☐ Diabetes
☐ Tingling in legs	☐ UTI's	☐ Sunlight sensitivity	☐ Cancer
☐ Numbness in toes	☐ Difficulty urinating	☐ Allergies	☐ Skin conditions

☐ Other (please explain):

Health history continued

Do you have any difficulty, dysfunction or loss of any of the following?

- ☐ Vision
- ☐ Hearing
- ☐ Smell/taste
- ☐ Swallowing
- ☐ Speech
- ☐ Breathing
- ☐ Heart
- ☐ Digestion
- ☐ Sexual function
- ☐ Other (Please explain): .....

Diet

Please mark any dietary selection that is appropriate for you and grade according to the following scale

D=Consume daily
FD=Consume few times a day
W=Consume weekly
FW=Consume few times a week
M=Consume monthly
FM=Consume fortnightly

- ☐ Alcohol
- ☐ Coffee
- ☐ Soft drinks
- ☐ Refined sugar
- ☐ Artificial sweetener
- ☐ Water
- ☐ Dairy
- ☐ Eggs
- ☐ Weight control diet
- ☐ Diet foods
- ☐ Fasting
- ☐ Fast food
- ☐ Canned vegetables
- ☐ Beef
- ☐ Poultry
- ☐ Tobacco
- ☐ Organic food
- ☐ Fruit
- ☐ Raw vegetables
- ☐ Wholegrains
- ☐ Seafood

Stressors

Please list your current top 3 stressors in each category

Physical stress (falls, accidents, work posture etc)

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Biochemical stress (smoke, unhealthy food, missed meals, not enough water, drugs/alcohol etc)

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Psychological stress (work, relationships, finances, self-esteem etc.)

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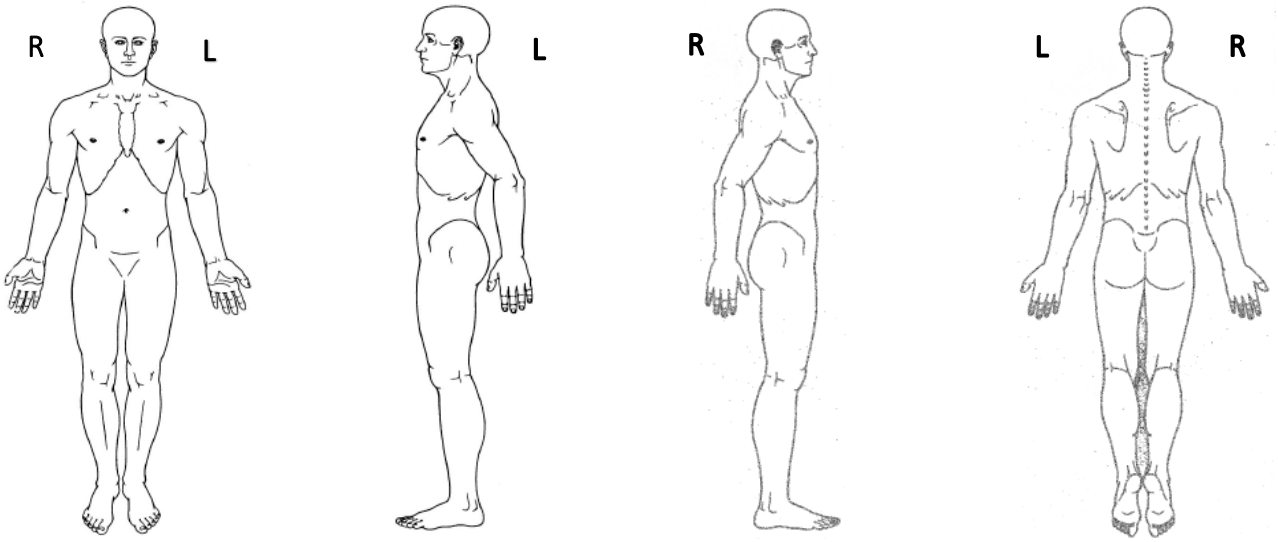
Current Health

If you have no symptoms or complaints and are here for Chiropractic Wellness Services please tick here ☐ ***or***

Please list below your current health concerns to their severity*:*

List physical concern	Rate of Severity 1=mild, 10=worst	When did this start?	If you had the concern before, When?	Did the problem begin with an injury?	% of time pain present
1					
2					
3					
4					

Please mark on the diagram below the areas of: P=pain, A=Ache, S=Sensation changes, M=Restricted movement



Health objectives

People consult the Karrinyup Wellness Centre with one or more of the following health objectives. Please indicate which apply to you.

- ☐ Relief of my symptoms
- ☐ Correction of my underlying problems
- ☐ To maximise my health
- ☐ To maximise myself, my family's and community health

Please rate the following questions out of 10: (1= minimum, 10 = maximum)

How would you rate your overall health?_____ /10 How would you like your health to be?_____ /10

How would you rate your physical health?_____ /10 How would you rate your mental health?_____ /10

How would you rate your spiritual health?_____ /10

Thank you for completing your health history form, our entire team looks forward to assisting you with your health journey. Your Chiropractor will be with you shortly.