



## Welcome to Vida Chiropractic!

*The purpose of this office is to help people get well and stay well.*

Please take some time to complete all questions as thoroughly as possible so our team can assess how we can best help you.

### PERSONAL INFORMATION

<b>Full Name:</b>		<b>Date:</b>	
<b>Address:</b>			
<b>Home Telephone:</b>		<b>Work Phone:</b>	
<b>Mobile Telephone:</b>		<b>Email Address:</b>	
<b>Best Time/Place to Contact You:</b>			
<b>Date of Birth:</b>		<b>Age:</b>	
<b>No. of Children:</b>		<b>Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	
<b>Marital Status: M S W D</b>		<b>Spouse/Guardian Name:</b>	
<b>Occupation:</b>			
<b>Spouse's Occupation:</b>			
<b>Hobbies/Interests/Sports:</b>			
<b>Do you have health insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/></b>			
<b>Are you a pension card holder? Yes <input type="checkbox"/> No <input type="checkbox"/></b>		<b>Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	

Have you received chiropractic care before? If so, from whom and when?

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Who may we thank for referring you? \_\_\_\_\_

### ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE

*If you have no symptoms or complaints and are here for Chiropractic wellness services, please skip to the "General Health History".*

#### Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Are these conditions interfering with any of the following:

<input type="checkbox"/> Work	<input type="checkbox"/> Sleep	<input type="checkbox"/> Daily routine	<input type="checkbox"/> Sports/exercise	<input type="checkbox"/> Hobbies/Interests	<input type="checkbox"/> Other
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Please explain:

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Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? [ie. eat better, less alcohol or drugs, meditate or breathe more, less contact sports, activities, etc]. If yes, what?

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## GENERAL HEALTH HISTORY

Often times, accumulation of life's three main stressors can lead to health problems and influence our ability to heal. Please pay close attention to this section as it will help us help you!

### First Main Stressor - Physical Stressors

Have you had any surgery? [Please include all surgery]

1. Type:	When?
2. Type:	When?
3. Type:	When?

Have you had any accidents and/or injuries: car, work-related, or other [especially those related to your present problems]?

1. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>

Please tick the appropriate answer for each of the following questions:

	Yes, daily/almost daily	Yes, occasionally	Not at all
Do you exercise?			
Do you play contact sports?			
Do you sit for long periods of time?			
Do you regularly bend and lift?			
Do you spend more than 2 hours per day using a computer?			

Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Yes No

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? Yes No

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

### Second Main Stressor - Bio-Chemical Stressors

#### Diet

Please tick the dietary selection that is appropriate for you for each of the following:

	Daily	Weekly	Monthly	Do not consume
Alcohol				
Fruit				
Fish				
Dairy				
Eggs				
Coffee/Tea				
Soft/Energy Drinks				
Refined Sugars				
Skip Meals				
Beef				
Fried Foods				
Raw Vegetables				
Artificial Sweetener				
Poultry				
Organic Foods				
Seafood				
Tobacco				
Diet Food				
Whole Grains				
Canned Vegetables				

Personal satisfaction with diet [please tick]:

<input type="checkbox"/> Highly Satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Unsatisfied	<input type="checkbox"/> Highly Unsatisfied
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## Current Medicines and Supplements

Please list any medications/drugs [prescription and non-prescription] you have taken in the past 6 months and why:

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Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

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## Third Main Stressor - Mental/Emotional Stressors

Have any of the following occurred recently:

<input type="checkbox"/> Depression	<input type="checkbox"/> Divorce	<input type="checkbox"/> Drugs/Alcohol Increase	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Death	<input type="checkbox"/> Change in Job Status	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Family Problems
<input type="checkbox"/> Increased Work Stress	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Economic Stress	<input type="checkbox"/> Other

Please comment if appropriate:

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## HEALTH HISTORY

Please mark the following conditions you may have had or have now:

<b>Neck Pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Numbness in Fingers</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Nervousness</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Stiff Neck</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Shoulder Pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Tension and Irritability</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Headaches</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Cold Feet/Hands</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Fatigue</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Sleeping Problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Dizziness</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Loss of Smell/Taste</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Depression</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Fainting</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Cold/Flu</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Lower Back Pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Ears Ring</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Allergies</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Pins and Needles in Legs</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Balance Loss</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Pain in Mid-spine</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Shortness of Breath</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Numb Toes</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Cold Sweat</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Weight Problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Chest Pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Hearing Problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Stomach/Digestive Problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Fever</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Light Bothers Eyes</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Constipation or Diarrhea</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Loss of Memory</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Menstrual Pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Pins and Needles in Arms</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Diabetes</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Asthma</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition

Other [please explain] \_\_\_\_\_

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## HEALTH STATUS

Using the 0 – 10 scale below, with 10 being excellent health, please circle what you believe to be your current state of health.

0            1            2            3            4            5            6            7            8            9            10  
 Very Poor            Poor            Average            Good            Excellent

## HEALTH GOALS

Which of these health goals are the most important to you? Please pick up to 5 and number them from 1 [most important] to 5 [least important]:

<input type="checkbox"/>	<b>Energy Level and Fatigue</b> – Do you feel energetic or are you tired of being tired?
<input type="checkbox"/>	<b>Quality of Sleep</b> – Do you have difficulty falling or staying asleep?
<input type="checkbox"/>	<b>Memory and Ability to Focus</b>
<input type="checkbox"/>	<b>Digestion</b> – Do you have problems with reflux, heartburn, bloating, etc.?
<input type="checkbox"/>	<b>Nutrition</b> – How healthy is your diet?
<input type="checkbox"/>	<b>Mood</b> – Are you happy, anxious, sad, or depressed?
<input type="checkbox"/>	<b>Stress Levels</b> – How well are you handling the stresses in your life?
<input type="checkbox"/>	<b>Allergies and Immune System</b> – Do you take allergy medication? Are you often sick?
<input type="checkbox"/>	<b>Understanding more about health and how you and your family can stay healthy</b>
<input type="checkbox"/>	<b>Pain Control/Relief</b>

Are there any other health goals or conditions you'd like to work on?

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In what ways do you feel that your life is restricted?

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What is the best thing that will be added to your life when you regain your health?

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## INFORMED CONSENT

There are many concerns about the safety of procedures we undergo routinely, the environment we live in, and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Vida Chiropractic will enhance your experience.

Most people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.

If you are [or have been] taking anticoagulant [blood thinning] medication or steroids then it is important to tell your chiropractor this prior to commencing care.

There are always risks associated with any therapeutic intervention! Regarding manual spinal adjustment the risk of permanent injury or death is approximately 1 in 2,500,000. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for aches and pains is approximately 3 in 1000. Statistically there is more chance of being hit by lightning than experiencing permanent damage or dying from a manual adjustment.

We must explain these risks to you so that you can make an informed decision about commencing, or continuing your care. If you have any further concerns please ask your chiropractor.

The adjustments and care you receive here at Vida Chiropractic will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

When you refer friends and family to see us for chiropractic care, we like to recognise your trust and confidence in us by acknowledging you on a notice. Please let us know if you would prefer not to be thanked publicly.

I have read the above and give authority to Vida Chiropractic to commence/continue chiropractic care for either myself or my dependent [whichever is applicable].

Signed: \_\_\_\_\_

Name [please print]: \_\_\_\_\_

Witness: \_\_\_\_\_