YOUR HEALTH HISTORY

Welcome to our office! Please answer all questions in as much detail as possible to assist us in guiding you on your wellness journey.

Date:

Title: First Name: Surname: DOB: Age Address: Postcode: Mobile number: Home number: Work number: Email: Preferred method of contact: ☐ Mobile ☐ Home ☐ Work ☐ Email	Children's Names & Ages: Occupation: Emergency Contact Details Name: Relationship: Phone number:

Who may we thank for referring you?

Please indicate if you would like further information about the following health topics or services:

Services available at Health Align:
☐ Pilates ☐ Nutrition ☐ Massage ☐ Bowen Therapy ☐ Personal Development

Health Workshop Topics:
☐ Men's Health ☐ Children's Health ☐ Fertility ☐ Healthy Body Image ☐ Toxins in the home
☐ Specific Health Condition (please specify) ____________________

Current Health Status and Goals:

Please detail below your current health issues:

Have you seen any other healthcare practitioners about this?

Is this condition interfering with any of the following?
☐ Work ☐ Sleep ☐ Daily Routine ☐ Sport/Exercise ☐ Mood ☐ Other (please specify)

Office use only: Practitioner ____________________

Current Symptoms

Please rate out of 3 the average severity of the following symptoms including frequency.
0 = symptoms not present, 1 = mild, 2 = moderate, 3 = severe

Symptom	**0**	**1**	**2**	**3**	**Frequency** **e.g. daily, weekly, monthly**
Back pain – general					
Lower back pain					
Neck pain					
Joint pain/stiffness					
Pain/tightness between shoulders					
Hip pain					
Leg pain/cramps					
Chest pain					
Numbness/tingling					
Arthritis					
Migraines/headaches					
Allergies/sinus					
Asthma/Bronchitis					
Colic					
Menstrual problems					
Infertility					
Constipation					
Diarrhoea					
Bloating					
Indigestion/heartburn					
Heart disease/circulatory					
Cholesterol high/low					
Bladder problems					
Diabetes					
Fatigue/low energy levels					
Fluid retention					
High/low blood pressure					
Depression					
Recurrent colds/flu/infections					
Weight problems					
Varicose veins/ulcers					
Tendency to bruise easily					
Skin problems					
Other					

Medical History

Are you currently taking any prescription or over the counter medications?

Please detail any past medical conditions or surgery:

Family History

Do you have any history in your family of medical conditions such as heart disease, stroke, cancer, diabetes, high blood pressure?

Lifestyle Factors

At work, do you mainly? ☐ Sit ☐ Stand ☐ Lift ☐ Bend ☐ Twist

Do you work full-time or part-time (please circle)

Please rate your level of physical activity: ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-7 times/week

What sports/recreational activities do you participate in? And the average time per week:

Please rate your level of stress: ☐ Low ☐ Medium ☐ High

Average number of hours sleep per night:

How many glasses of water do you drink each day (exclude tea, coffee, fruit drinks):

Do you smoke? ☐ Yes ☐ No If yes, how many per day?

Do you drink alcohol? ☐ Yes ☐ No If yes, how many units per week?
(1 unit = 1 small glass of wine, 1 can beer, 1 nip spirits)

Female Section Only

Are you pregnant?	☐ Yes	☐ No
Are you breast feeding?	☐ Yes	☐ No
Are you planning to conceive?	☐ Yes	☐ No
Have you had any difficult pregnancies/miscarriages?	☐ Yes	☐ No

Chiropractic Section Only

Please tick which of the following is your current priority:
☐ Spinal Health Check ☐ Quick Fix ☐ Treat the cause of symptoms and correct spinal alignment

Have you been to a chiropractor before? ☐ Yes ☐ No

Have you ever had a postural evaluation before? ☐ Yes ☐ No
If yes, by whom?

What was the Program of Care that you were offered?
☐ Symptomatic relief ☐ Corrective plan ☐ Unsure

Were you happy with your results?

What is your current perception of chiropractic?
☐ Last resort for back pain ☐ Wellness Experts ☐ Bone crunchers ☐ No clear perception

Are you nervous about receiving chiropractic treatment here? If so, why?

GP Details

Doctor's Name: Clinic Name:
Address:
Phone:

In order to collaborate for your best outcome, we may send a report to your doctor to advise of our findings and your progress. Do you authorize us to release any medical information required to your doctor? ☐ Yes ☐ No

Consent

I, (print name) have answered all questions contained on this form accurately. I consent to having further particulars taken regarding my health concerns and to receiving all future treatments by my practitioner. I have had and continue to have the opportunity to discuss safety issues and any concerns with my practitioner.

Signature: Date:

Consent for a minor

I, (print name) being the parent/ uardian of (print name of child) hereby consent to my child receiving care at Health Align

Signature: Date: