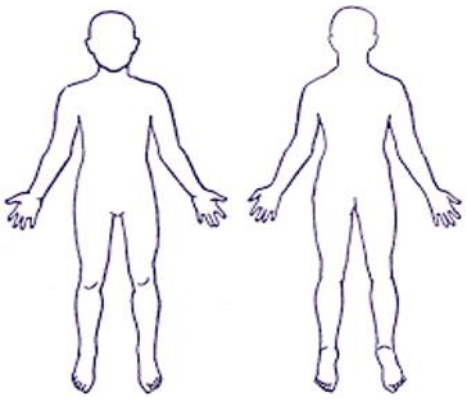
SPINE FINE
CROSS HANDS CHIROPRACTIC CLINIC LTD

Date completed:

TITLE	FIRST NAME:	SURNAME:
PREFERRED NAME:		DOB:
CONTACT TELEPHONE NUMBER:	ALTERNATIVE NUMBER:	
ADDRESS		
POSTCODE	EMAIL ADDRESS	
EMERGENCY CONTACT NAME / TELEPHONE NUMBER: Are they nominated to speak on your behalf? YES / NO		
INSURANCE INFORMATION Self-funding ☐ Private Medical ☐ Insurance details		
GP NAME & ADDRESS		

CURRENT CONDITION	
LOCATION OF SYMPTOMS (please mark on the diagram)  FRONT BODY BACK BODY	HOW WOULD YOU DESCRIBE THE PAIN? (Sharp / Dull ache / etc?) START DATE
DURATION OF PAIN Occasional ☐ Intermittent ☐ Constant ☐	IS IT A RESULT OF AN ACTIVITY / EVENT? Please specify

WHAT AGGRAVATES IT?	WHAT ALLEVIATES IT?

HAVE YOU TAKEN ANY MEDICATION FOR THIS CONDITION?
Please specify

ARE YOU CURRENTLY TAKING ANY MEDICATION FOR THIS OR ANY OTHER CONDITION?
YES ☐ NO ☐

Please specify

HAVE YOU SEEN, OR ARE YOU SEEING ANY OTHER PRACTITIONER FOR THIS CONDITION?
(physio / Osteo / Chiro / Dr / Consultant etc)

PAIN SCALE (Please circle)

Day time: **NONE** 0 1 2 3 4 5 6 7 8 9 10 **WORSE**

Night time: **NONE** 0 1 2 3 4 5 6 7 8 9 10 **WORSE**

MEDICAL HISTORY
If you answer yes to any questions, please specify

DO YOU HAVE A HISTORY OF FAMILY ILLNESS?

HAVE YOU UNDERGONE ANY OPERATIONS / MEDICAL PROCEDURES/ INVESTIGATIONS / IMAGING?

HAVE YOU HAD ANY ACCIDENTS / VEHICLE COLLISIONS / FALLS / SPORTING INJURIES?

HAVE YOU EVER SUFFERED WITH ANY OF THE FOLLOWING?	YES	NO	DETAILS
ALLERGIES			
CARDIAC COMPLAINTS			
JOINT PAIN			
CANCER			
OSTEOPORSIS			
NEUROLOGICAL CONDITIONS			
THYROID CONDITIONS			
SKIN CONDITIONS			
RESPIRATORY CONDITIONS			
EPILEPSY			
GALL BLADDER / LIVER CONDITIONS			
BOWEL / BLADDER CONDITIONS			
NIGHT SWEATS			

HAVE YOU EVER SUFFERED WITH ANY OF THE FOLLOWING?	YES	NO	DETAILS
URINARY CONDITIONS			
THROMBOSIS			
LOW / HIGH BLOOD PRESSURE			
DIABETES			
MIGRAINES / HEADACHES			
MENTAL HEALTH ISSUES			
HEAMATOLOGICAL CONDITIONS			
HIV / AIDS			
STROKE			
DIGESTIVE ISSUES / IBS			
REPRODUCTIVE CONDITIONS			

WOMEN ONLY	DETAILS
CURRENT METHOD OF BIRTH CONTROL	
REGULAR PERIOD CYCLE	
PREGNANCIES	
MENOPAUSE	

LIFESTYLE HISTORY			
OCCUPATION TYPE: MANUAL ☐ SEDENTARY ☐ ACTIVE ☐ HIGH STRESS ☐ NONE ☐			
CURRENT EMPLOYER			
HOURS SPENT SITTING PER DAY	0 – 2	3 – 5	MORE THAN 5
HOURS SPENT STANDING PER DAY	0 – 2	3 – 5	MORE THAN 5
ACTIVITY / EXERCISE FREQUENCY	0 – 2	3 – 5	MORE THAN 5
WHAT TYPE OF ACTIVITY / EXERCISE DO YOU DO?			
HOURS OF SLEEP PER NIGHT	LESS THAN 5	MORE THAN 5	
ALCOHOL UNITS PER WEEK	0 – 2	3 – 5	MORE THAN 5
CAFFEINE CUPS PER DAY	0 – 2	3 – 5	MORE THAN 5
WATER / HERBAL TEA PER DAY	0 – 2	3 – 5	MORE THAN 5
FRESH FRUIT / VEG PER DAY	0 – 2	3 – 5	MORE THAN 5
DIET	Poor 0 1 2 3 4 5 6 7 8 9 10 Fantastic		
SMOKER	NO ☐	YES ☐	AMOUNT ☐

SUBSTANCE ABUSE	yes ☐											no ☐	

STRESS LEVEL OVER THE PAST WEEK	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
MOOD OVER THE PAST WEEK	**Depressed / Sad**	0	1	2	3	4	5	6	7	8	9	10	**Happy / Joyful**
ENERGY LEVEL OVER THE PAST WEEK	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**

CURRENT LIMITATIONS TO ACTIVITIES

EXPECTED GOALS / OUTCOME / DESIRES FOR SEEKING CARE WITH SPINE FINE CHIROPRACTIC

ANYTHING ELSE WE SHOULD KNOW?

Clinic Administration: (please tick)

How did you hear about the clinic?

Google ☐ Facebook ☐ Website ☐ Passing by ☐ Friend / family ☐

Who can we thank for recommending us?

Name:

Address: