CORE WELLNESS
CENTRES

Confidential Patient Details

Full Name: _____ DOB: _____ Age: _____ M ☐ F ☐

Address: _____ Post Code: _____

Email Address: _____

Home Ph: _____ Mobile Ph: _____ Work Ph:_____

Occupation: _____ Employer's Name: _____

Status: Single ☐ Married ☐ Cohabiting ☐ Widowed ☐ Separated / Divorced ☐

Partner's Name: _____ Names/Ages of Children: _____

Name and Practice of GP:_____

Who may we thank for referring you to our office? _____

Addressing The Issues That Brought You To The Office

What brings you to us? _____

How long have you had it? _____ D/W/M/Y How did it start? _____

If you are experiencing pain is it….

Sharp/Shooting ☐ Dull/Aching ☐ Throbbing ☐ Burning ☐ Numb/Tingling ☐

Since the problem started is it….

About the same ☐ Getting better ☐ Getting worse ☐ Is it …… On/Off ☐ Constant ☐

What makes it worse? _____ What relieves it? _____

Yes, it interferes with: Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐

Have you had it before? No☐ Yes ☐ If yes, how often and since when? _____

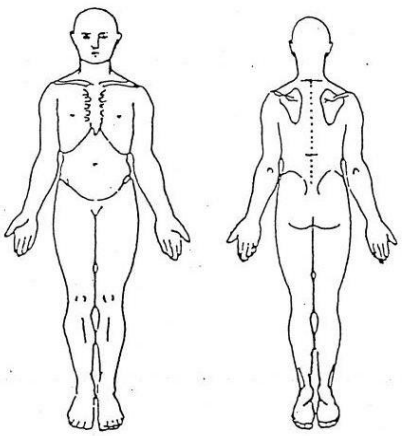
Who else have you seen for this problem? _____

Do you have any other health concerns? _____

Tick past (P) or current (C) if you have ever had:

P	C		P	C	
☐	☐	Headaches/Migraines	☐	☐	Neck Stiffness
☐	☐	Dizziness/ Loss of balance	☐	☐	Osteoporosis
☐	☐	Ringing/Buzzing in ear	☐	☐	Fatigue / Irritability
☐	☐	Menstrual Pain/Irregularity	☐	☐	Prolonged steroid use
☐	☐	Changed Bowel/Bladder Control	☐	☐	Sudden/Recent weight loss
☐	☐	Indigestion / Heartburn	☐	☐	Sleeping problems
☐	☐	Other Digestive problems	☐	☐	Heart Disease
☐	☐	Blood Pressure Problems	☐	☐	Blackouts or blurry vi sion
☐	☐	Stroke or Transient Ischemic attack	☐	☐	Increased urinary frequency
☐	☐	Pains/Sweats waking you at night	☐	☐	Cancer: _____
☐	☐	Recurrent/Persistent sinusitis	☐	☐	Pins/Needles in arm/fingers
☐	☐	Recurrent ear/nose/throat infections	☐	☐	Pins/Needles in legs/feet
☐	☐	Asthma	☐	☐	Diarrhoea
☐	☐	Diabetes	☐	☐	Constipation
☐	☐	Fainting	☐	☐	Sexual problems
☐	☐	Anaemia	☐	☐	Thyroid disease

Mark / label all areas of pain, stiffness or abnormal sensation:



Front View Back View

On the diagram above:-

A. What number do you think represents your health today?_____

B. In what direction is your health currently heading? _____

Have you had any spinal x-rays taken in the last 12 months? No ☐ Yes ☐

Please state any major illnesses or any surgeries and years: _____

_____

List traumas (Car-whiplash/home/sports/work injuries etc.) and years: _____

_____

Family Health Profile:

At Core Wellness Centres we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones.

Do you or any of your family suffer from?

Diabetes ☐ Heart problems ☐ Stroke ☐ Epilepsy ☐ Cancer ☐ Orthopaedic Problems ☐

Please mention below any other health conditions or concerns you may have about family members:-

Children ☐ Spouse ☐ Mother ☐ Father ☐ Brothers ☐ Sisters ☐ Others ☐

_____

Female Clients:-

Are you currently pregnant? No ☐ Yes, I am due _____ Number of past pregnancies? _____

Have you any health concerns regarding this pregnancy? _____

Allergies, Medications & Supplements

Allergies (list)	Medications (list)	Supplements (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

DECLARATION: This information is accurate to the best of my knowledge. My signature below will also serve as consent for any examination procedures deemed appropriate/necessary by the chiropractor.

Signature: (parent/guardian to sign for minors):_____

Date:_____