

Personal History

Our lives consist of a wide variety of experiences, stresses and challenges. These can be physical (accidents, falls, poor posture, lack of exercise), chemical (poor diet, alcohol, drugs, pollution) or emotional (relationships, work pressure, behaviour). Sometimes we are unable to deal with the full impact of an event at the time it occurs. Regardless of whether the experience was a positive or negative one, we can often hold on to it physically, emotionally and mentally. This stored experience then has the potential to create tension, discord and dis-ease in the body, interfering with its self-healing capacity.

At Light Chiropractic and Wellness we use a subtle, refined chiropractic method to release this interference, allowing your body's communication systems to function more effectively. Our intention is to support you in achieving life and health improvements.

Name Client Number Date

DOB Relationship status Partner's Name

Children (ages) Occupation

Address

Suburb State Postcode

Home Work Mobile

Email

Please fill out the following questions as completely as you can, your answers will help us to understand you better.

Do you currently (C) have or have you had in the past (P) any problems with the following:

	C	P		C	P		C	P		C	P			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Night pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ears ringing (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Severe/changed cough	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Shooting pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tingling (pins & needles)	<input type="checkbox"/>	<input type="checkbox"/>

What has brought you to this office and how do you hope to benefit from the care given here? (Please tick all that apply)

Symptom relief	<input type="checkbox"/>	Improved health and wellbeing	<input type="checkbox"/>
Less tension/increased flexibility	<input type="checkbox"/>	Improved ability to cope with stress	<input type="checkbox"/>
Better posture	<input type="checkbox"/>	Greater energy levels	<input type="checkbox"/>
Personal growth	<input type="checkbox"/>		

Please describe

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Please list all major physical traumas that you have experienced (falls, accidents, broken bones, etc - include dates)

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Please list any major surgery, including major dental or orthodontal work (include dates)

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Have you ever been unconscious?

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Have you had any serious illness?

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Do you have any x-rays? When were they ordered and by whom?

Are you pregnant? (How many months?)

Have you had a baby recently? (Date?)

Are you currently/ previously been active in any sports? (Which ones? Frequency?)

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Do you make any repetitive movements or hold any prolonged postures during the course of your day? (work and home)

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Birth history (if known): forceps suction natural caesarian breach long labour

Please describe, with dates, any significant emotional stresses experienced

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Please describe any current emotional stresses (work, relationships, health concerns, etc)

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Please list any current medications and your reasons for taking them

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Please list any medications taken in the past and why

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Please describe any intake of or exposure to chemical toxins in the past

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How would you describe your diet?

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Do you smoke? How many per day?

Do you use recreational drugs? How often?

Is there any other information which may help us to better understand you that has not already been covered?

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How did you find out about us?

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Important Information

Many people come to our office when they are feeling great and some visit us for health conditions like low back pain, headaches, arthritis, depression, chemical addictions, digestive problems etc. However, please remember that the aim of chiropractic is not the treatment of disease or conditions, but rather the optimisation of your health. Sometimes people notice their body detoxifying after adjustments, which can express itself as headaches etc. You may also at times notice old aches and pains resurfacing or emotions releasing. This is all part of working with stored tensions and energy in your body. As your experiences and perceptions change with this work your life will change.

Any practitioner who uses manipulation is required to inform patients of possible adverse reactions. Over the years there have been rare incidents of stroke or stroke like symptoms (usually temporary), which have occurred after neck manipulation. The chance of this happening is 1 in 5.85 million (Neck manipulations Haldeman, et al. Spine vol. 24-8 1999). There is more chance of being hit by lightning than having such a reaction. No one in Australia has died from neck manipulation. There are other small risks, which include muscle and joint strains and sprains, where full recovery follows. Numerous physical tests with or without x-rays help to minimise the risk of any adverse reactions to your treatment. If you have any further questions please do not hesitate to ask.

Patient Signature Date