Trinity Chiropractic

Maximising your potential

Confidential heath and wellness questionnaire

Our team believes that health is much more than just how you feel! True health and wellbeing means you are physically, mentally and emotionally at your best. People are individuals and what works for one may not for another. Therefore the questions below are designed to get an overall impression of your current health and lifestyle. This information gives an accurate picture of where we are starting together and allows our team to best assist as you begin achieving your health and lifestyle goals.

About you

Full Name Date

Address

Postcode

Telephone H W M

Email

Best time/place to contact you

Date of birth Age No. of children

Spouse/guardian name

Your Occupation

Who may we thank for referring you?

What do you enjoy doing most in life?

LIFESTYLE

Movement and Physical Activity

It is important to note that you don't have to be a super athlete to be fit – any activity that moves your body, be it supermarket shopping or chasing after the children counts.

How many times on average do you exercise (any form of physical activity that you do over a specific time period deliberately for your fitness/health aims) in a normal week (include if you train more than once in a given day)?

What do you normally do? At what intensity? (e.g. low, moderate or high intensity)

What other activities do you do that have you moving in a normal week?
Please explain. (ie. walking to the supermarket, walking the baby, cleaning the house etc.)

What exercise and sports have you done in the past?

If you feel you are not doing enough, what stops you from moving and exercising as much as you would like?

What do you think is sufficient exercise and movement for you?

Do you have any physical and exercise goals?

Nutrition and eating habits

Please briefly describe your regular diet: what are the main foods you eat?

How much water do you drink in a day?

Do you drink alcohol? If so how much on average per week?

Do you drink coffee? If so how many cups per day?

What else do you drink? (Coke, tea etc)

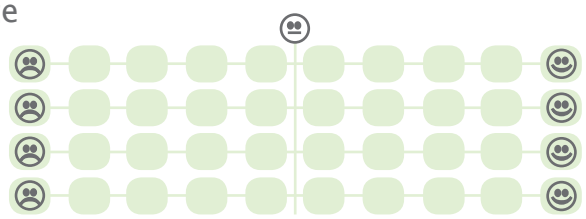
Do you have any allergies or sensitivities to food?

What are your favourite 'naughty' foods and drinks?

Do you have any nutritional goals?

Mental and emotional wellbeing

On a scale of 1 (☹) -10 (☺) please rate



Your general health

What is your level of perceived stress?

How well do you feel you cope with your stress?

General frame of Mind

Is there anything you are struggling with or dealing with in your life right now that is affecting your ability to be healthy, fit and well?

Are you aware of the mind/body connection and how that affects your overall health?

General

Do you smoke? Past/present? How many per day?

Are you exposed to any other chemicals or toxins? (Food/environmental/work)?

On average how many hours of sleep do you get each night?

Do you sleep well and wake refreshed?

When you have some symptoms of ill health what is your first reaction? i.e. what do you think to do and where do you go to get well?

What other things do you do to be healthy? (supplements/massage etc)

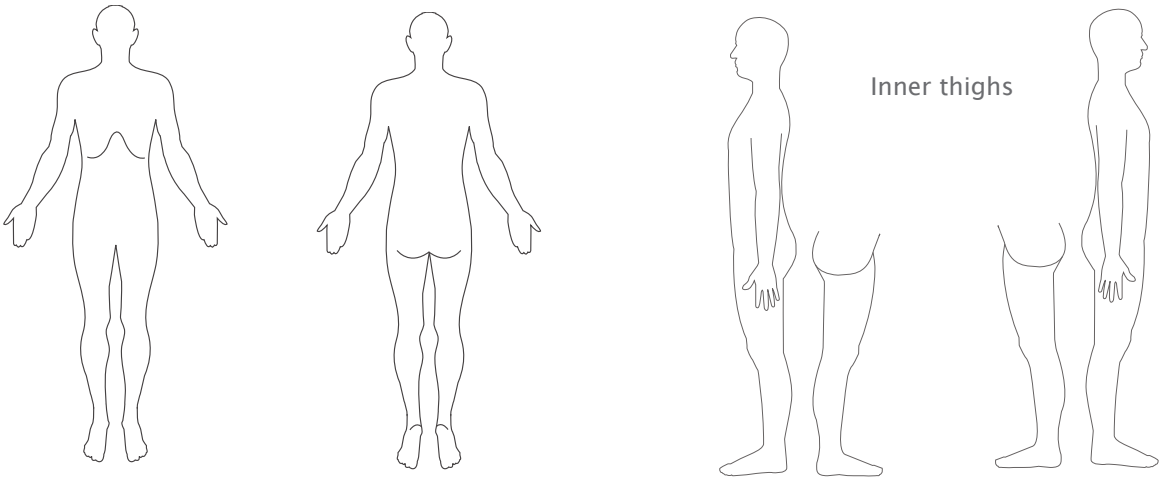
HEALTH

Current

Do you have any health challenges currently?

Please mark below any areas of concern, pain or discomfort.

Front Back Left Right



How long have you had this problem? Have you had this before?

Have you sought any other treatment for this/these issues?

What treatment did you use?

What medications are you currently taking?

When was the last time you saw your medical doctor?

MEN Have you ever had a prostate check?

WOMEN Are you pregnant? Are you trying to get pregnant?

Do you have regular menstrual cycles?

Do you have any pain/PMS etc associated with your cycle?

Past Health History

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

- Heart disease
- High blood pressure
- Breathing difficulties
- Asthma
- Digestive complaints
- Numbness/Tingling
- Diabetes
- Epilepsy
- Eczema
- Thyroid problems
- Neck pain
- Mid back pain
- Low back pain
- Headaches/migraines
- Sinus problems
- Low immunity
- Dizziness
- Ringing in ears
- Depression
- Anxiety
- Low energy
- Concussion
- Arthritis
- Allergies
- Fracture
- Cancer

Major accident, injury or illness (please explain)

Have you taken any long-term medications?

What are these medications?

Spine and Nervous System

Have you seen a chiropractor before?

If so, when and for how long?

How would you rate your posture on a scale of 1 (☹) -10 (☺)?

Are you aware of your posture throughout any given day?

Goals

What is the main goal you hope to achieve from chiropractic care?
(wellness, performance, healthier, pain relief, etc)

If you could improve any other areas of your life, which of these would they be?

Energy levels	Digestion	Fatigue
Quality of Sleep	Bowel function	Breathing
Immunity	Pain	Allergies
Headaches	Bladder function	Asthma
Flexibility	Muscle strength	Athletic performance
Daily activities	Ringing in ears	Response to stress
Quality of life	Muscle tension	Mental creativity
Stiffness	Numbness & Tingling	Concentration
Happier	Better balance	

How long do you think it will take to make the desired changes to your current health?

Informed consent

Have you ever had any x-rays taken? Y / N

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for services is due at the time of my visit. I consent for my information being shared within the practice.

Print your Name

Date

Signature