Welcome to think.

To help us to know more about you and your health status and needs please complete the following form

(Please talk to reception if you have any queries)

287 Kepa Road
Kohimarama 1071
ph 09 521 2045 f
email - think.kohichiro@gmail.com

Personal Information

Todays Date:_____

Full Name:_____ Preferred Name:_____ Date of Birth:_____

Address:_____ Suburb:_____ Town:_____

Marital Status: *(circle 1)* - *Single / Married / De-Facto / Divorced* Spouses Name:_____

Phone Number: Home:_____ Work:_____

Mob:_____ ☐ (Please tick if you do not wish to receive SMS communications – predominantly reminders)

Email Address:_____ ☐ (Please tick if you do not wish to be on our email mailing list)

Emergency Contact:_____ Relationship to you:_____ Contact no:_____

Your Occupation:_____ Your G.P.:_____ Contact no:_____

Previous Chiropractic Care: ☐ *Yes* ☐ *No* If *'yes'* then with whom:_____ Approx last visit:_____

Do you have any children? Names and ages?:_____

How did you find out about us?_____
(If it is an existing patient please tell us their name so we may thank them)

The healthy function of every cell, tissue & organ in our bodies is dependent upon the integrity of the nervous system. This system consists of the brain, spinal cord and spinal nerves. Protecting these vital structures are the skull and the vertebrae of the spine. Chemical, Physical and Emotional stresses can distort the normal motion of the spinal bones interfering with the flow communication between the body and the brain. When this occurs it called a vertebral subluxation.

This questionnaire will help reveal the causes of vertebral subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and well-being.

Health History

What has brought you into our practice today?_____

_____

What do you think has caused this problem?_____

When did this problem begin?_____

Is the problem getting better, getting worse or unchanged since it began?_____

Was it: ☐ Sudden onset ☐ Gradual onset ☐ Result of an accident - if accident have you filled out an ACC form? Yes / No

Have you had this complaint before in the past? ☐ Yes ☐ No If 'yes' then when?_____

Have you sought care for this problem previously? ☐ Yes ☐ No If 'yes' then when and with whom? (e.g. Physio, Osteo, G.P etc)

_____

Does anything make the problem worse? ☐ Yes ☐ No If 'yes', what?_____

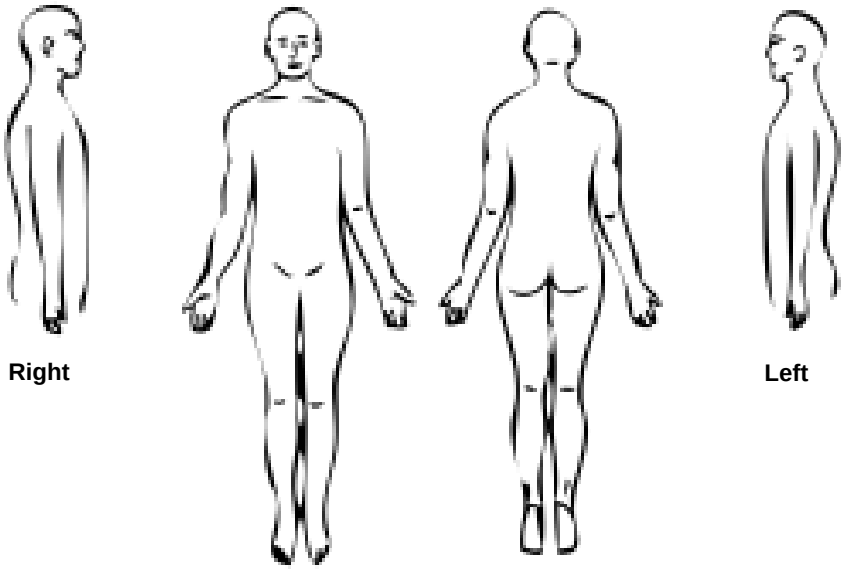
Does anything make the problem better? ☐ Yes ☐ No If 'yes', what?_____

Are there any daily activities that you have difficulty with or can no longer do?_____

Please circle the severity of your problem using the following scale if applicable:

1	2	3	4	5	6	7	8	9	10
No pain									Extreme pain

On the diagram, please draw where you feel concern, pain or symptom(s)



Please check the following descriptor(s) that describe what you feel in relation to your current problem(s):

☐ Sharp	☐ Numbness	☐ Cool/Cold
☐ Dull	☐ Tingling	☐ Stiffness
☐ Achy	☐ Stabbing	☐ Tightness
☐ Burning	☐ Shooting	☐ Tension

☐ Other _____

Past History

Have you ever had any trauma? (e.g. car accidents, falls, sports injuries etc) ☐ Yes ☐ No
If 'yes'; when and where? _____

Have you ever broken any bones? ☐ Yes ☐ No if 'yes'; when and where? _____

Have you had any previous surgeries? ☐ Yes ☐ No Surgery (for what specific issue) Date:

Are you on any medications currently? ☐ Yes ☐ No Medication: Reason for taking:
if 'yes' please give the details:

Have you ever been treated for any major illness/conditions? ☐ Yes ☐ No if 'yes' please give details below:

Are there any health problems that run in your family: _____

Please tick as appropriate if you have experienced any of the following in the **past** or at the **present:**

Past	Pres	GENERAL
		Headaches / migraines
		Loss of energy
		Depression
		Nervousness or anxiety
		Diabetes
		Cancer
		Stroke
		Allergies or hay fever
		Weight gain / loss
		Concussion
		Epilepsy / convulsions
		Dizziness or fainting spells
		Nausea or vomiting
		Fever / chills
		Night sweats
		Loss of sleep

Past	Pres	EYES, EARS, NOSE &
		Recurring earache(s)
		Ringing in the ears / tinnitus
		Deafness
		Visual disturbances / changes
		Eye pain
		Recurring sinus infection
		Recurring sore throat /
		Recurring colds
		Enlarged thyroid / goitre
		Enlarged glands
		Ulcers
		Hoarseness

Past	Pres	WOMENS HEALTH
		Irregular periods
		Painful/heavy periods
		Menopausal symptoms
		Breast Lumps
		Ovarian cysts
		Miscarriage
		Pregnant

Past	Pres	CARDIO-VASCULAR
		Coronary heart disease
		High blood pressure
		Low blood pressure
		Pain over heart
		Poor circulation
		Angina
		Rapid heartbeat
		Slow heartbeat
		Swelling of ankles

		GASTRO-INTESTINAL
		Always hungry / thirsty
		Loss of appetite
		Irritable bowel disease
		Food allergies
		Stomach ulcer
		Stomach pain
		Hernia
		Diarrhea
		Constipation
		Difficult digestion
		Inability to control bowel
		Liver trouble / jaundice
		Gallbladder trouble
		Hepatitis
		Vomiting blood
		Bloody stools
		Haemorrhoids
		Reflux / indigestion

		RESPIRATORY
		Difficulty
		Asthma
		Wheezing
		Chronic cough
		Chest pain
		Spitting / coughing up blood
		Tuberculosis (TB)
		Rheumatic fever

Past	Pres	MUSCLE & JOINT
		Arthritis
		Neck pain or stiffness
		Upper back pain
		Shoulder / arm pain
		Low back pain
		Sciatic / leg pain
		Hip / knee pain
		Ankle / foot pain
		Disc injury
		Muscle weakness
		Gout
		Fractures
		Jaw pain / TMJ
		Pins & needles
		Numbness
		R.S.I. / O.O.S.
		Osteoporosis
		Poor posture
		Spinal curvatures

		GENITO-URINARY
		Frequent urination
		Inability to control
		Painful urination
		Recurring bladder
		Kidney trouble
		Kidney stones
		Prostate trouble
		Blood in urine
		STD's
		Bedwetting

Is there any further information you would like us to know?

Lifestyle - *Physical, chemical and mental stressors*

There are three types of stressors that can have a direct impact on our spine and nervous systems resulting in vertebral subluxation. Physical stressors (i.e. accidents/sports, poor posture and/or the birth process); chemical stressors (poor nutrition, drugs/medication and/or environmental toxins); and emotional stressors (relationships, family illnesses, bereavements, work stress); all have major impacts upon our nervous and immune systems.

How many glasses of water do you drink daily? _____

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

What is your daily caffeine intake? _____

How would you describe your diet? _____

How often do you exercise?_____

What type of exercise do you do? _____

	Very high	*High*	*Moderate*	*Low*	*Very low*
In general, would you say your health is	1	2	3	4	5
In general, would you rate your quality of life is	1	2	3	4	5
In general, how would you rate your physical health ?	1	2	3	4	5
In general, how would you rate your mental health? (including your mood & ability to think)	1	2	3	4	5

In the past **7 days** have you regularly experienced any of the following: (please circle any that apply)

Fatigue/Tiredness	Grumpiness	Irritability	Anxiety/Nervousness	Depression	Poor concentration
Insomnia / Poor sleep	Negative thoughts/attitude	Hyperactivity	Anger	Low motivation	Easily losing patience

	Very high	*High*	*Moderate*	*Low*	*Very low*
How would you rate your current level of stress? (circle)	1	2	3	4	5
In general, how would you rate your satisfaction with your social activities and relationships?	1	2	3	4	5
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend ect.)	1	2	3	4	5
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries etc?	1	2	3	4	5
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable ?	1	2	3	4	5
How would you rate your fatigue on average?	1	2	3	4	5

Consent for care

As with all health care professionals the law now requires practitioners who adjust the spine to inform patients of material risk. Chiropractic adjustments of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and many other alternatives. (A risk assessment cervical of manipulation, JMPT, 1995.Magna Report, Ontario Ministry of Health, 1993). In extremely rare circumstances some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke like symptoms. This is extremely rare occurring in approx 1 in 5.85 million (Haldeman, et al. Spine, 1999, Vol 24-8). Whilst this has never occurred in this practice, we are still required to impart this information. Before you receive any adjustments you will be tested to minimise risk, as has always been our practice. If you have any questions related to the care you are about to receive please speak to the chiropractor.

Please sign below if you give permission for the chiropractor to examine and administer care as deemed necessary. For patients under the age of 18, a parental guardian must sign below.

Signature:_____ **Date:**_____