Wishaw Chiropractic Clinic

Dr Gavin Sinclair, Doctor of Chiropractic
Dr Francis Kelly, Doctor of Chiropractic

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•Mr/Mrs/Miss/Ms/Dr: …… •Surname: ……
•Forename: …… •Middle Name: ……
•Current Age: …… •Date of Birth (DD/MM/YYYY): ……
•Street Address: ……
•City/Town:…… •County/Province:…… •Postcode:……

•Telephone (Home):…… •Telephone (Work): ……
•Telephone (Mobile):…….. •Email: ……

About You

•Occupation:
……..
•Marital Status: …… •Number of children: ……
(Married/Single/Divorced etc.) •Ages of Children: ……

•G.P. Name and Address:
……
……

•How did you hear about us? •If recommended, please state by whom:

…… ……

Chiropractic History

•Have you been to a chiropractor before? ☐ Yes ☐ No
•Name of Last Chiropractor and Location: ……..
……
•What are your health goals? ☐ Symptom Relief ☐ Symptom Management ☐ Correct Underlying Problem

Major Health Concern **(Please fill in all areas: if not applicable please put N/A)**

•What condition brought you to our office? (If any)
……
……
•On a scale of 1-10 (10 being severe), how bad is the problem? ……/10
•When did it start? •How? ……
…… ……
•Is it: ☐ Getting Better ☐ Getting Worse ☐ Staying the same
•How would you describe the problem?
……
•Are you taking any medication for this condition? ☐ Yes ☐ No
•If yes, which medication? ……
•Please list all other medications you are currently taking:
……
……
•What else have you tried to relieve the problem? (E.g. Ice, heat, physiotherapy, massage etc)
……

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Your Health History

•Have you ever or are you currently experiencing any of the following conditions?
(Please tick all that apply, whether currently experiencing, or have experienced in the past)

	Current	Past		Current	Past
Headaches			Asthma		
Migraines			Cancer		
Dizziness			Arthritis		
Stroke			Heart Disease		
Ear Infections			Diabetes		
Tinnitus			Fatigue		
Neck Pain			Back Pain		
Numbness & Tingling			High blood pressure		

•Do you have any other medical conditions that are not listed above? (Please specify)
……
……
……

•Sleep Posture: ☐ Side ☐ Stomach ☐ Back ☐ Restless

•Have you seen your medical doctor in the last 6 months? ☐ Yes ☐ No

•If yes, what for?……

•Have you had x-rays in the last 6 months? ☐ Yes ☐ No

•If yes, what for?……

•Name of hospital where x-rays taken:……

•Have you ever had any operations, including major dental treatment? ☐ Yes ☐ No

•If yes, what for? ……

•Have you had any falls, accidents or injuries that may be involved with your present complaint? ☐ Yes ☐ No

•If yes, please explain:
……

•Have any of your family members suffered any serious illnesses? (E.g. cancer; stroke; heart attack; neurological problems; arthritis etc.) ☐ Yes ☐ No

•Relationship to you: ……
……

•Condition: ……
……..

Stresses

•Rate your stress level on an average day (Please circle number)

1 2 3 4 5 6 7 8 9 10

Very low Moderate Very High

•Does your daily activity involve any of the following? (Please tick all that apply)

☐ Prolonged Sitting ☐ Prolonged Standing ☐ Computer/Desk Work
☐ Heavy Lifting ☐ Repetitive Motions ☐ Studying