Enkindle Wellness

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CONFIDENTIAL PERSONAL INFORMATION

Personal Information

Full name:	**Date:**
Address: **Post Code**	
Home phone:	**Work phone:**
Mobile phone:	**Email address:**
Date of birth:	**Age:** **Female** ☐ **Male** ☐
Occupation:	**Are you pregnant?** **Yes** ☐ **No** ☐
No. of children: **Ages/Names:**	
Have you ever had Chiropractic care? **Yes** ☐ **No** ☐ **If Yes, how long ago?**	**Is this a WorkCover or Motor Accident case?** **Yes** ☐ **No** ☐
Marital status: **Single** ☐ **Married/Defacto** ☐ **Widow/er** ☐ **Divorced** ☐	
Spouse/guardian name:	

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Care, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start? (days/weeks/ months or years)	If you have had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is pain associated with your Health Concerns? If so is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

1._____2._____

_____

3._____4._____

_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

_____

Do you have a family history of this or similar symptoms: No ☐ Yes ☐ (If yes, please explain):

_____

Which activities aggravate your condition? _____

_____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐

Other doctors you have seen for these conditions:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Other (please describe)	☐

Doctor's details:

Name:	Clinic:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?

Name:	Clinic:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, changed activity level, etc.) If so, what?

_____

_____

What have you learnt about yourself from your healing process to date?

_____

_____

General Health History

Accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?
2. Type:	When?
3. Type:	When?
4. Type:	When?

Have you had any accidents and/or injuries: car, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalised? Yes ☐ No ☐
2. Type:	When?	Hospitalised? Yes ☐ No ☐
3. Type:	When?	Hospitalised? Yes ☐ No ☐

Have you ever had x-rays taken which are relevant to your present problem areas?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Past Health History

Please mark the following conditions you **Have Had** ☒ **or Have Now** ☑

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis (blocked arteries)	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please list)

_____

_____

Current Medicines and Supplements

Please list the conditions for which you have taken any medications/drugs in the past 6 months: (prescription and non-prescription)

_____

_____

Please list the reasons or conditions for which you currently take any nutritional supplements, vitamins, homeopathic remedies:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If changes to the foods you eat are indicated, would you be willing to make changes?	Yes ☐ No ☐ Maybe ☐
Would you take nutritional supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Rate the following on a scale of 1 to 10 (please circle)

The overall movement and flexibility in your **neck**	Very stiff – 1 2 3 4 5 6 7 8 9 10 - Very flexible
The overall movement and flexibility in your **mid back**	Very stiff – 1 2 3 4 5 6 7 8 9 10 - Very flexible
The overall movement and flexibility in your **low back**	Very stiff – 1 2 3 4 5 6 7 8 9 10 - Very flexible
Rate your **posture**;	Poor 1 2 3 4 5 6 7 8 9 10 = Excellent

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, injuries, work postures, physical abuse, difficulties with your birth etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy foods, fumes, don't drink enough water, drugs/alcohol, prescription medication, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological or mental/emotional stress (work, relationships, family, finances, rapid change of life situations, etc.)
   a. _____
   b. _____
   c. _____

Circle the number that applies to you in each of the areas below:

My **stress level at work** (physical, mental/emotional, and chemical stresses) is;	no stress – 1 2 3 4 5 6 7 8 9 10 - totally stressed
My **stress level at home** (physical, mental/emotional, and chemical stresses) is;	no stress – 1 2 3 4 5 6 7 8 9 10 - totally stressed
My **stress level at play** (physical, mental/emotional, and chemical stresses) is;	no stress – 1 2 3 4 5 6 7 8 9 10 - totally stressed
My **eating** habits are:	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **exercise** habits are:	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **sleeping** pattern is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **general health** is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **mind set** is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **energy level** is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **physical health** is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My **mental/emotional** health is;	very poor – 1 2 3 4 5 6 7 8 9 10 - excellent
My life has a **sense of purpose**;	unsure – 1 2 3 4 5 6 7 8 9 10 – very clear
Overall my **health** is ;	1 = getting better 2= not changing 3 = getting worse

Is there anything else, which has not been mentioned, which may help us to better understand you?

_____

_____

Why are you here at this point in time?

_____

_____

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

Enkindle Wellness protects your privacy and personal information. Our Practice Privacy Policy is available on our website.