Northcote Chiropractic

Adult Health History

Date:

Surname: ____________________ Age: ________

Forename(s): ____________________ Preferred Name: ____________________ DOB: ________

Address: ____

____

Home Tel: ____________________ Work Tel: ____________________ Mobile: ____________________

Email: ____________________ Occupation: ____________________

Marital Status: S ☐ M ☐ D ☐ W ☐ Partners Name: ____________________

Names of Children & Ages: ____

____

Who have you received Chiropractic care from in the past? ____________________

____

Who referred you to Northcote Chiropractic? ____________________

Your body is designed to be healthy. There is always a cause or reason to why it is not.
Throughout life many events occur that may damage your health.

The following questions will help us assess any layers of dysfunction, particularly to your nervous system, that have adversely affected your health. All information will be handled in the strictest of confidence. Please tick where appropriate.

Your Birth

The birth process can be quite traumatic on both mother and baby and is often where spinal dysfunction may first occur.
Was your birth:

☐ Unassisted ☐ Caesarean ☐ Premature ☐ Breech ☐ Prolonged labour

☐ Forceps/Suction ☐ Short duration ☐ Induced ☐ Drug assisted ☐ Homebirth

☐ Unsure

Your Childhood

As a child did you experience:

☐ Colic ☐ Mumps ☐ Eczema ☐ German/Measles ☐ Other

☐ Bedwetting ☐ Allergies ☐ Always tired ☐ Tonsillitis/throat infection ☐ Unsure

☐ Ear Infections ☐ Asthma ☐ Chicken Pox

As a child were you:

☐ Breast fed ☐ Formula fed ☐ A head banger ☐ Bum Shuffling ☐ Didn't crawl

☐ Unsure

As a child did you:

☐ Have any major accidents ☐ Have a flat head ☐ Require antibiotics ☐ Fall down stairs ☐ Have turned feet

☐ Have surgery ☐ Crawl before walking ☐ Have difficulties at school ☐ Use calipers ☐ Have Torticollis

☐ Require medication ☐ Use a baby walker ☐ Sleep on your stomach ☐ Have flat feet ☐ Unsure

Were you vaccinated as a child: ☐ Yes ☐ No ☐ Unsure

Accidents/Injuries/Medical Intervention

Name and Practice of GP: ______________________________

Have you ever suffered:

☐ Broken bones, Age ____ ☐ Sprains, Age ____ ☐ Concussion, Age ____

☐ Motor vehicle accidents, Age ____ ☐ Fainting/Unconsciousness, Age ___ ☐ Dental procedures, Age ____

☐ Other, Age ____

Please give details: ______________________________

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____

Have you ever been hospitalised for any other illness or surgery?
Describe: ______________________________

____

____

Do you take any medication/drugs (prescription/non prescrition) ______________________________

____

____

Do you take any supplements ______________________________

Have you ever had x-rays, scans or MRI (Please give dates and details)? ______________________________

Your lifestyle:

	Yes	No	Unsure
Do you smoke?	☐	☐	☐
Do you drink alcohol	☐	☐	☐
Do you drink adequate water?	☐	☐	☐
Do you eat health foods?	☐	☐	☐
Do you sleep well?	☐	☐	☐
Are your teeth healthy?	☐	☐	☐
Do you exercise regularly?	☐	☐	☐

	Yes	No	Unsure
Are you physically stressed?	☐	☐	☐
Are you mentally stressed?	☐	☐	☐
Are you being, or have you been, exposed to chemicals?	☐	☐	☐
Are you taking or taken drugs?	☐	☐	☐

Sports:______________________________

Hobbies:______________________________

Have you experienced a loss in the past 5 years? (e.g relationship, family, business, financial) ______________________________

____

Your Health Objectives:

People consult this clinic with one or more of the following health objectives. Please indicate which apply to you.

☐ Relief of my symptoms

☐ Correction of my underlying health problems

☐ To maximise my health

☐ To maximise myself, my family's and community health.

You may have specific reasons for consulting this practice. If this is the case what are they? ______________________________

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How would you rate your overall health ? ___/10 What would you like your health to be? ___/10

Informed Consent Information

There are many concerns about the safety of procedures we undergo routinely, the environment that we live in and the food that we consume to name but a few. We hope to explain some of the risks and common responses to chiropractic care so that your concerns may be eased and that you have a better understanding of the adjustments you will be receiving.

Most people will experience some level of discomfort in the early stages of care. This is due to the body settling down and adjusting to new mechanical patterns of movement. It is actually quite a normal response during the initial stages of care.

If you are (or have been) taking any anti-coagulant (blood thinning) or steroid based medication then it is important to tell your chiropractor before care commences. It is also prudent to inform them of any other any other medication you may currently or have previously been taking.

There is a risk of approximately 1 in 1,000,000 adjustments of permanent injury or death associated with manual manipulation or adjustments of the spine. To place this in perspective, the risk of death from gastric bleeding when taking an asprin or paracetamol for your aches and pains is 3 in 1000 or 7 in 1000 of dying during surgery.

We must explain these risks to you so that you can make an informed decision about beginning or continuing your care. If you have any further worries or questions, please feel free to ask your chiropractor.

The adjustments and care you receive will be tailored to you and your specific health needs. If at any stage of care you are uncomfortable, have doubts or questions then please express them to your chiropractor. Our technique of adjustment can be adapted to suit almost any person, age or condition.

I, ______________________________________(print name) have read this "Important information for patients".
I fully understand that the purpose of my spinal examination today and any assessment received in this clinic in the future is to detect the presence of vertebral subluxations. I understand that at this clinic our Doctors of Chiropractic are not practicing as Medical Doctors, Osteopaths or Physiotherapists. Their purpose is to detect and correct 'Vertebral Subluxations' in order to allow my body to function and heal at its Optimal Potential. I hereby consent to a chiropractic physical examination and adjustment.

Signature____Date ________________________
Patient Signature (Legal Guardian)

Northcote Health Services Limited GDPR Consent

In order to continue storing and using your data, we require your consent to do so. We use your personal information for the following purposes: To keep patients informed by post, email or telephone (including SMS) on appointments, clinic information and events and offers. This includes correspondence about subscriptions, care plans, appointment reminders, clinic staffing updates and opening times, newsletters, publicity about future social & clinic events, etc. and for other reasonable purposes, always acting within the limits of the General Data Protection Regulation.

We will never will never sell, rent, loan or share your personal data with a third party for the purpose of marketing activity of any nature, unless you have provided us with explicit permission to do so. A copy of our Privacy Policy is available on the Clinic website and from the Clinic reception. You can withdraw your consent at any time by emailing manager@northcotechiropractic.co.uk or using the unsubscribing link contained at the bottom of all email communications received by the Clinic.

☐ I give my consent for Northcote Chiropractic to continue to store and use my data

☐ I do not give my consent for Northcote Chiropractic to continue to store and use my data

Signature____Date ________________________
Patient Signature (Legal Guardian)

Marketing Consent

Northcote Chiropractic occasionally uses photographs and / or testimonials for marketing purposes. These are posted onto our social media channels i.e. Facebook, Twitter, Instagram etc. Please indicate below if you agree for us to use your photographs or comments as part of our marketing activity.

☐ I give my consent for Northcote Chiropractic to use my photographs, testimonials and comments for general marketing purposes

☐ I do not give my consent for Northcote Chiropractic to use my photographs, testimonials and comments

Signature____Date ________________________
Patient Signature (Legal Guardian)

Many thanks for your time and consideration. We look forward to working with you.

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