hertfordchiropractic
treatment centre

Date: ……

Personal Details

Name: …… Preferred Name: ……

Address: ……

……Post Code:……

DOB: …… Marital Status: ……. Email: ……

Home Tel: …….. Mobile: …… Work Tel: ……

Is it okay to contact you at work? no □ yes □

(Please inform us of any changes to your personal details)

Employment details

Occupation: …….. Previously: ……..

Health Details

GP Name and Address: ……

Ok to contact GP surgery? 0 no 0 yes

Please list any drugs or medications you are or have taken recently or if you have taken any in the past for a period of time ……

……

……

And any vitamins/minerals/herbs/homeopathics……..

Are you pregnant? 0 no 0 yes – If yes since when? ……..

General

Have you ever had chiropractic care before? 0 no 0 yes

If yes, state where and with whom: ……..

How did you find out about this practice? ……

Are you receiving care from other health professionals? 0 no 0 yes

If yes, please name them and their specialty ……..

Do you have health cover? 0 no 0 yes – if yes with whom? ……

Please list any hobbies or activities (gym, reading, PC) ……..

Consent

I consent to an appropriate chiropractic physical examination

Signed: …….. Date: ……...

HAVE YOU OR ANY BLOOD RELATION SUFFERED WITH PROBLEMS IN THE FOLLOWING AREAS?

Area	√ As Appropriate	Age	Comments By Chiropractor
Heart / Stroke			
Lung / Breathing			
Digestive			
Bowel / Bladder			
Kidney			
Reproductive			
Circulation			
Blood Pressure			
Diabetes			
Cancer			
Nervous Disorder (Epilepsy, MS, Parkinson's,Schizophrenia)			
Allergies			
Skin Disorder			
Headaches /Migraines			
Eyes / Ears / Nose / Throat			
Tinnitus (Buzzing In Ears)			
Dizziness			
Arthritis / Orthopaedic			
Osteoporosis			
Psychological / Depression			
Psychiatric / Mental Disorders			
Other Problems			