COASTLINE Chiropractic CENTRE

Helping you restore your body's balance and freedom

Present State of Health

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major symptom/problem _____

Pain / Problem started on _____ triggered by _____

Have you had previous episodes of this problem? ☐ No ☐ Yes: No. times: _____
Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent
Is the pain referring to other areas of your body? ☐ No ☐ Yes: Where? _____
Is condition getting worse? ☐ No ☐ Yes
What brings on your condition or makes it worse? _____
What relieves your condition or makes it feel better? _____
Is this symptom/condition interfering with: ☐ Work ☐ Sleep ☐ Routine
☐ Other (please specify) _____

Have you seen other Doctors/Practitioners seen for this condition? ☐ No ☐ Yes
If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other
Please list any home remedies employed: _____

DAILY ACTIVITIES

Do your daily activities involve:
☐ sitting ☐ walking ☐ heavy lifting
☐ writing ☐ driving ☐ manual work ☐ repetitive tasks
☐ standing ☐ phone use ☐ desk work ☐ emotional stress

Do you play a musical instrument? ☐ No ☐ Yes
Do you read for prolonged periods? ☐ No ☐ Yes
Do you wear: ☐ dentures / a plate ☐ glasses or bifocals ☐ contact lenses

Please describe:
Sleeping posture ☐ side ☐ back ☐ stomach
Sports you play or used to play _____ ☐ currently play ☐ used to play
_____ ☐ currently play ☐ used to play
_____ ☐ currently play ☐ used to play
_____ ☐ currently play ☐ used to play

Are you trying to: ☐ Gain weight ☐ Lose weight ☐ Neither
Do you exercise? ☐ Daily to weekly ☐ Occasionally ☐ Never
Do you smoke? ☐ No ☐ Yes: _____ per day
Do you sleep well? ☐ No ☐ Yes. Approx. hours of sleep per night _____

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Medications

Medication Names	*Dosage*	*Reason for the use*

Have you received chiropractic care before? ☐ No ☐ Yes

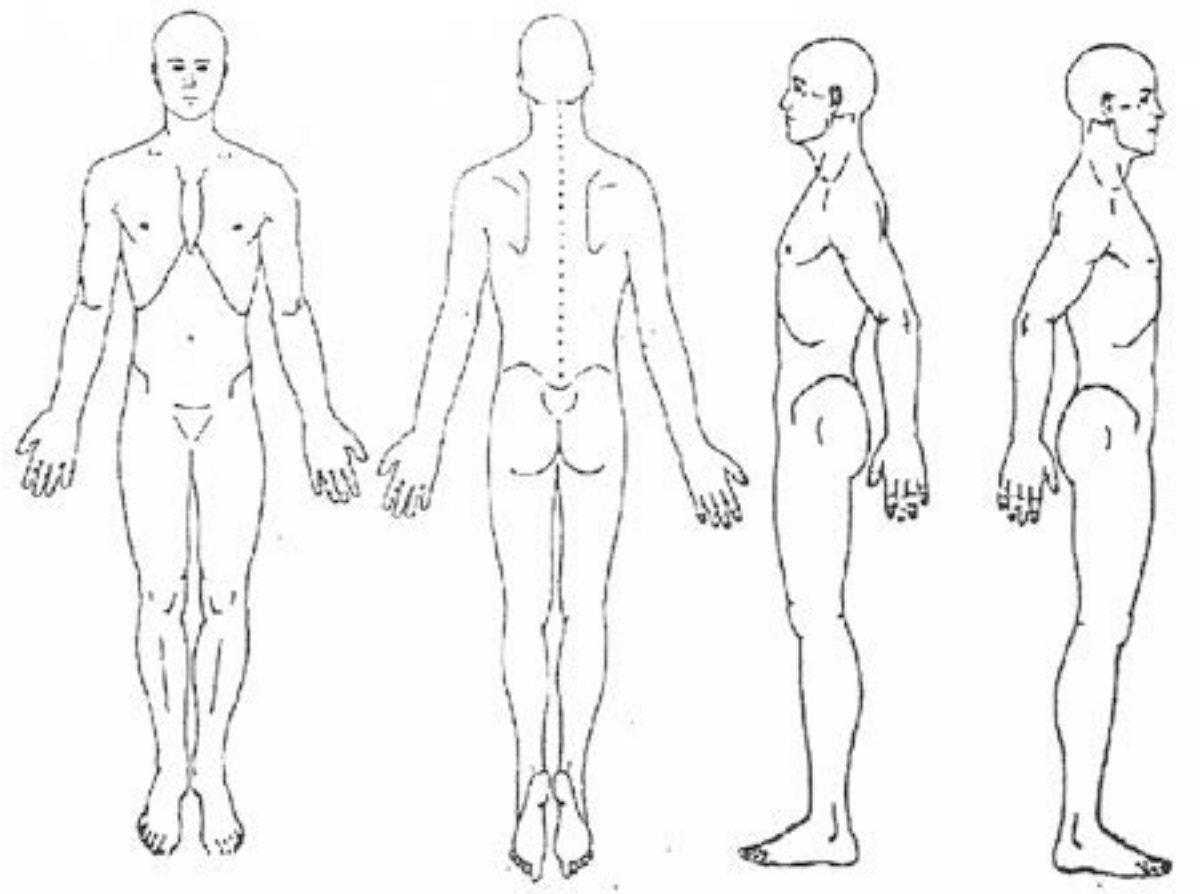
If yes, when was your last visit?_____

Were you pleased with the service provided?_____

Have you ever had any spinal X-rays taken? ☐ No ☐ Yes. When? ____/____/____

Which spinal areas: ☐ neck ☐ mid-back ☐ low-back ☐ pelvis

Please mark on the diagram below where your complaint areas are: -



PLEASE NOTE:
This section will be completed in the centre.

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