

**PLEASE ANSWER THE FOLLOWING QUESTIONS, GIVING DETAILS AND DATES:-**

What sort of birth did you have? Natural  Caesarian  Forceps  Vacuum Extraction (Ventouse)  Cord Complications

Have you had any surgery? YES  NO  Please state:.....

Have you ever broken any bones? YES  NO  Please state:.....

Have you had any vehicle accidents sports injuries  severe falls  electric shocks  Please state:.....

Have you ever been concussed or in a coma? YES  NO  Please state:.....

Have you required major treatments, investigative tests or x-rays in the past? YES  NO  Please state:.....

Have you ever had any shock treatment or drugs for a nervous breakdown or depression? YES  NO  Please state:.....

Are you currently attending hospital or seeing a hospital specialist?.....

Do you consider yourself to be under stress?: Marital  Domestic  Financial  Workplace

Have you received Chiropractic care? YES  NO  Name:.....

Is there anything else you feel you should mention about your health?.....

Please indicate hobbies or sports that you participate in:.....

<b>DIETARY INTAKE PER DAY:</b> (Please state amount day)	
NO. OF CUPS OF COFFEE/TEA:.....	AMOUNT OF SUGAR:.....
GLASSES OF COKE:.....	CHOCOLATES/SWEETS:.....
GLASSES OF MILK:.....	ALCOHOL:.....
GLASSES OF WATER:.....	TOBACCO:.....

WHAT MEDICATION / DRUGS ARE YOU CURRENTLY TAKING		
DRUGS	DOSE	REASON
1		
2		
3		
4		

IT IS UNDERSTOOD AND AGREED THAT ANY X-RAYS TAKEN BY OR ON BEHALF OF THIS CLINIC ARE AN IMPORTANT PART OF THE PATIENT'S PERMANENT RECORD AND AS SUCH WILL REMAIN THE PROPERTY OF THIS CLINIC. IN ACCORDANCE WITH THE NATIONAL RADIOLOGICAL PROTECTION BOARD REQUIREMENTS ALL EXPOSURES ARE KEPT WITHIN REGULATION GUIDELINES AND ARE RECORDED.

SIGNATURE.....

DATE.....

PLEASE INDICATE ON THE DIAGRAMS WHERE YOU HAVE BEEN EXPERIENCING PAIN

<b>FOR WOMEN ONLY</b>	
PREGNANT AT PRESENT <input type="checkbox"/>	
PAINFUL MENSTRUATION <input type="checkbox"/>	
IRREGULAR CYCLE <input type="checkbox"/>	
EXCESSIVE FLOW <input type="checkbox"/>	
VAGINAL DISCHARGE <input type="checkbox"/>	
CYSTITIS <input type="checkbox"/>	
THRUSH <input type="checkbox"/>	
HOT FLUSHES <input type="checkbox"/>	
PREVIOUS MISCARRIAGE <input type="checkbox"/>	
INABILITY TO CONCEIVE <input type="checkbox"/>	
MASTITIS <input type="checkbox"/>	
MENOPAUSE <input type="checkbox"/>	
MOOD SWINGS <input type="checkbox"/>	
H.R.T <input type="checkbox"/>	
CONTRACEPTIVE PILL <input type="checkbox"/>	
OTHER <input type="checkbox"/>	
<p>IT IS NOT OUR POLICY TO X-RAY ANY WOMEN OF CHILD BEARING AGE UNLESS IT IS DONE WITHIN 10 DAYS OF THE ONSET OF THEIR LAST PERIOD.</p> <p>PLEASE INDICATE, IF APPLICABLE, THE DATE OF THE START OF YOUR LAST PERIOD.....</p> <p>TO THE BEST OF YOUR KNOWLEDGE ARE YOU PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>SIGNATURE.....</p>	

