It is a pleasure to welcome you to Chiropraxis Raffelsieper

CHIROPRAXIS
RAFFELSIEPER

YOUR PERSONAL DETAILS

Name

Surname

Date of Birth

Age

Occupation

Address

Email

Telephone

Spouse / Next of Kin:

Children: Name (Age)

Name (Age)

Name (Age)

Name (Age)

YOUR HEALTH GOALS

People and Families visit us for many reasons.

For us to meet your health needs, please tick ✔ from the following list:

- ☐ Relief of Symptoms
- ☐ Correction of an underlying problem
- ☐ To maximize my health
- ☐ To improve my family's and community's health

How can we help you today?

YOUR CURRENT LEVEL OF HEALTH & WELLBEING

Rate your OVERALL HEALTH:

Lack of overall health — 0 1 2 3 4 5 6 7 8 9 10 — Perfect overall health

Rate your PHYSICAL HEALTH:

Poor physical health — 0 1 2 3 4 5 6 7 8 9 10 — High physical health

Rate your ENJOYMENT OF LIFE:

Minimum enjoyment — 0 1 2 3 4 5 6 7 8 9 10 — High enjoyment

Rate your ability to DEAL with STRESS :

Low ability — 0 1 2 3 4 5 6 7 8 9 10 — High ability

Rate your ENERGY Levels:

Low energy levels — 0 1 2 3 4 5 6 7 8 9 10 — High energy levels

Rate your clarity of THOUGHT and CONCENTRATION:

Low clarity — 0 1 2 3 4 5 6 7 8 9 10 — High clarity

please turn over

FACTORS CONTRIBUTING TO YOUR LOSS OF HEALTH & WELLBEING

Your current level of health is always a reflection of your body's ability to deal with stressors placed on you throughout life. This section is designed to gather information about these layers of stressors.
Throughout the years you are exposed to three types of Stress: EMOTIONAL, CHEMICAL and PHYSICAL. As layers of damage from these stresses increases over the years, you may have experienced symptoms and random bouts of illness.

EMOTIONAL STRESSORS:

ON-OFF EMOTIONAL STRESSORS:

Have you suffered from any emotional or mentally stressful event or crisis throughout your life:

If yes, explain:

PROLONGED EMOTIONAL STRESSORS:

Have you in the past / or do you currently experience:

Stress in the workplace: ☐ Yes ☐ No / ☐ Past ☐ Currently

Stress with relationship: ☐ Yes ☐ No / ☐ Past ☐ Currently

Stress at home with family: ☐ Yes ☐ No / ☐ Past ☐ Currently

CHEMICAL STRESSORS:

MEDICAL CHEMICALS:

As a child were you vaccinated: ☐ Yes ☐ No

Have you been exposed to any chemicals: ☐ Yes ☐ No If yes, type:_____

Are you taking any medications at present: ☐ Yes ☐ No If yes, type:_____

Have you ever taken any long term medication: ☐ Yes ☐ No If yes, type:_____

Do you choose to have a flu shot: ☐ Yes ☐ No If yes, how often: _____

LIFESTYLE CHEMICALS:

Do you / Did you smoke: ☐ Yes ☐ No If yes, # per day _____

Drink Alcohol: ☐ Yes ☐ No If yes, # glasses day _____

Drink Water: ☐ Yes ☐ No If yes, # glasses day _____

Drink sugar drinks (Softdrinks, cordial): ☐ Yes ☐ No If yes, # glasses day _____

Drink Tea / Coffee: ☐ Yes ☐ No If yes, # cups day _____

Eat sugary foods (chocolate/sweets): ☐ Yes ☐ No If yes, how often _____

Do you have any food intolerances or allergies: ☐ Yes ☐ No If yes, type:_____

Eat fresh fruit & vegetables: ☐ Very Rarely ☐ 1-2 potions/day ☐ 3-4 portions/day ☐ more

ON-OFF PHYSICAL STRESSORS:

PHYSICAL STRESSORS:

Have you ever been in a Motor Accident: ☐ Yes ☐ No If yes, when:_____

What happened:_____

Please list any significant/memorable Accidents / Falls:

When: _____ What happened: _____

When: _____ What happened: _____

When: _____ What happened: _____

Was your birth difficult? (forces/vontouse/trauma) Yes No Explain:_____

Any broken Bones: ☐ Yes ☐ No If so, when: _____ Which bones: _____

Any surgery: ☐ Yes ☐ No If so, when: _____ What type: _____

Any Chronic Illness: ☐ Yes ☐ No If so, when: _____ What type: _____

PROLONGED PHYSICAL STRESSORS:

Does your work require Repetitive or Prolonged activities: ☐ Yes ☐ No If so, explain:

Does your work require to be seated for prolonged periods: ☐ Yes ☐ No

Sleeping posture: ☐ Side ☐ Stomach ☐ Back Sleep well: ☐ Yes ☐ No

Hobbies / Recreation / Sports: _____

How often do you exercise ☐ Never ☐ Rarely ☐ Often ☐ More than once a week

CONSENT

The aim of Chiropractic Health Care is not to treat your symptoms, but to get the cause of health problems and facilitate your body's natural health ability. This is done through natural means, without the use of drugs or surgery. I understand this and consent to a thorough examination including spinal.

Signature of Patient: Date

_____ / /