It is a pleasure to welcome you to Chiropraxis Raffelsieper

CHIROPRAXIS
RAFFELSIEPER

YOUR PERSONAL DETAILS

Name

Surname

Insurance:
☐ Private ☐ Gesetzlich

Date of Birth

Age

Occupation

Address

Email

Telephone

Referred (by whom)

Promotion(circle):
Mall / Workplace / Gym / Talk

Spouse / Next of Kin:

☐ Google ☐ Website ☐ Facebook ☐ Other

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 portions/day ☐ 3-4 portions/day ☐ more

PHYSICAL STRESSORS:

ON-OFF 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 / /