Office use Only:
Your chiropractor is
☐ Joe Williams
☐ Zoe Pantelios
CA _____

Referral Source:
☐ Internet
☐ Facebook
☐ Twitter
☐ Google
☐ Friend / Family
☐ GP / Midwife
☐ Leaflet
☐ Talk / Event

Chiropractic Intake & History

Please answer all the questions so we can assess how we can best help you

TWC CHIROPRACTIC

Patient Information

Patient First Name _____
Patient Last Name _____
Middle Initial _____
Address _____
City _____
County _____ Postcode _____
Home Phone _____
Mobile Phone _____
Email _____

☐ I give my consent to be added to the email newsletter to receive recent news, events and healthy tips.

Sex ☐ Male ☐ Female
Age _____
Birthday _____
Employer/School _____
Occupation _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Family Information

Children Names and Ages:

Partner Name _____
Partner Employer _____
Partner Occupation _____

GP Name _____
GP Surgery _____

How did you hear about the practice?

_____

How can we help you?

What brings you in today?

_____

How bad is it? How intense are your symptoms?

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

No Symptom — Intense Symptoms

Please describe where the pain or other symptoms are:

If you are already experiencing symptoms, what are they?

_____

Are your symptoms improving?
☐ Yes ☐ No ☐ No Change

What does it feel like? (Check where appropriate)
☐ Numbness ☐ Sharp ☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning ☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing ☐ Cramping ☐ Swelling
☐ Nagging ☐ Other _____

Have you seen any other professional for the above complaint(s)?
☐ GP ☐ Consultant Surgeon ☐ Physician
☐ Osteopath ☐ Acupuncture

Have you had
☐ MRI ☐ X-ray ☐ CT ☐ Blood tests
☐ Other _____

Old Injuries

Please list any historic injuries, when they occurred, what age you where and what treatment you received for them:

Are any of the injuries listed causing current issues?

_____

Impact of Your Symptoms

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

What makes it better? _____

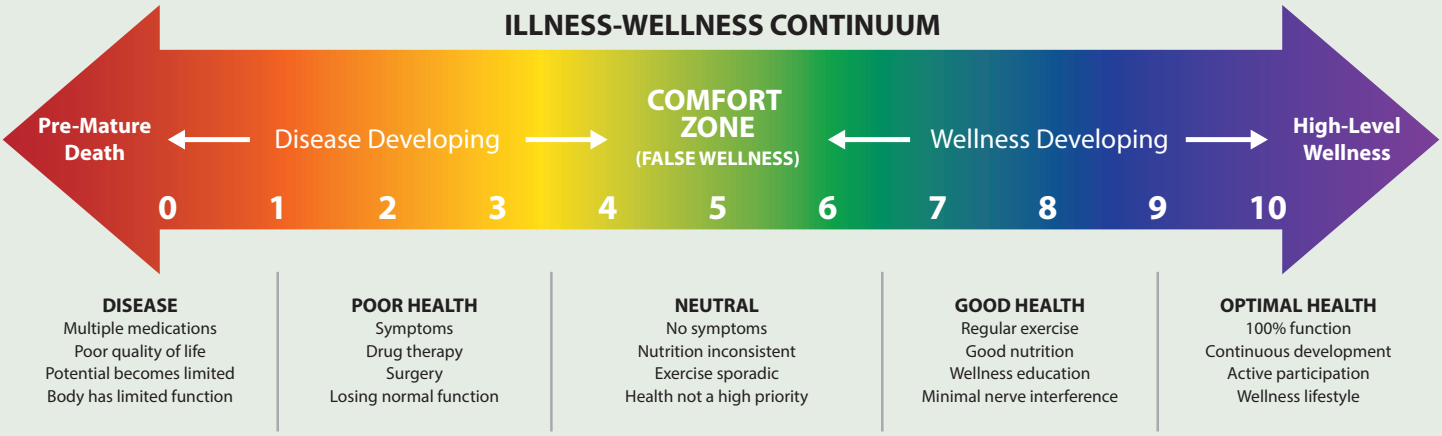
What makes it worse? _____

How committed are you to correcting the issue?

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Not Committed — Very Committed

Patient Wellness Assessment



DISEASE
Multiple medications
Poor quality of life
Potential becomes limited
Body has limited function

POOR HEALTH
Symptoms
Drug therapy
Surgery
Losing normal function

NEUTRAL
No symptoms
Nutrition inconsistent
Exercise sporadic
Health not a high priority

GOOD HEALTH
Regular exercise
Good nutrition
Wellness education
Minimal nerve interference

OPTIMAL HEALTH
100% function
Continuous development
Active participation
Wellness lifestyle

On the diagram above:

A. What number do you think represents your health today? _____

B. In what direction (left or right) is your health currently headed? _____

What would you like to get out of your chiropractic care?

_____

What are your health goals?

Immediate _____

Short term _____

Long term _____

Health & Illness History

Please check the box beside any condition that you have or have had.

Past	Present	
☐	☐	AIDS/HIV
☐	☐	Alcoholism
☐	☐	Anxiety
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Asthma/Allergies
☐	☐	Back Pain
☐	☐	Cardiovascular Issues
☐	☐	Cancer

Past	Present	
☐	☐	Circulation Issues
☐	☐	Childhood Illness
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Digestive Issues (Constipation/Diarrhoea/GERD/IBS)
☐	☐	Elbow/Wrist/Hand Issues
☐	☐	Endocrine Issues (Thyroid)
☐	☐	Foot/Ankle Issues

Past	Present	
☐	☐	Gout
☐	☐	Headaches/Migraines
☐	☐	Heart Disease
☐	☐	Hip Issues
☐	☐	Immune Issues
☐	☐	Lymphatic Issues
☐	☐	Multiple Sclerosis
☐	☐	Neck Pain
☐	☐	Reproductive Issues

Past	Present	
☐	☐	Ringing in Ears
☐	☐	Scoliosis
☐	☐	Shoulder Issues
☐	☐	Stroke
☐	☐	Jaw Pain
☐	☐	Urinary Issues
☐	☐	Osteoporosis
☐	☐	Other

_____

Family History Review

Please tick those involving immediate family and add identification:

M = Mother **F** = Father **S** =Sibling **G** = Grandparents

☐ **Cancer**, type_____
☐ M ☐ F ☐ S ☐ G

☐ **Heart Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Lung Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Seizures/Epilepsy**
☐ M ☐ F ☐ S ☐ G

☐ **Depression**
☐ M ☐ F ☐ S ☐ G

☐ **Liver Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Scoliosis**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoarthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Diabetes**
☐ M ☐ F ☐ S ☐ G

☐ **High Blood Pressure**
☐ M ☐ F ☐ S ☐ G

☐ **High Cholesterol**
☐ M ☐ F ☐ S ☐ G

☐ **Rheumatoid Arthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Back Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Neck Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Headaches/Migraines**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoporosis**
☐ M ☐ F ☐ S ☐ G

☐ Other
_____

Allergies, Medications & Supplements

Allergies (list)

Medications (list)

Supplements (list)

We would like to thank you once again for taking the time to complete ALL the questions, we really appreciate it! Welcome to the practice, sit down, relax and let us take care of your body!

Your Chiropractor will be with you shortly

Filling out this form digitally?
When you have completed the form simply save it and send the same PDF file back to Tunbridge Wells Community Chiropractic by email:
hello@twcchiropractic.co.uk