**Complete Care Physio**

**Please tell us more about your current situation:**

What are your current complaints?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had these complaints?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you currently take:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries or hospitalizations you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies/sensitivities you may have (drug or food):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else stands in the way of full expression of your health potential? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been to a Chiropractor before? ⁪ No ⁪ Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your family medical doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other health care professionals currently treating you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Compared to 5 years ago, are you: (*circle which apply*)⁪ More healthy ⁪ Less healthy ⁪ About the same

Are you satisfied with your current perceived overall health status? ⁪ Yes ⁪ No

**Family History**

Please check if your mother, father or siblings have experienced any of these conditions:

Mother Father Siblings

Diabetes \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_⁪ ⁪ ⁪

Heart Disease \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ ⁪ ⁪ ⁪ \_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_⁪ ⁪ ⁪ \_\_\_\_\_\_\_\_\_\_

Arthritis ⁪ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ ⁪ ⁪ \_\_\_\_\_\_\_\_\_\_

Other family history that you feel is important:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daily Habits** (*circle which apply*)

Exercise: ⁪ Heavy (Competitive Training) ⁪ Daily (4-7 times/wk) ⁪ Moderate (1-3 times/wk) ⁪ None

Work Activity: ⁪ Heavy Labor ⁪ Light Labor ⁪ Standing ⁪ Sitting/Desk/Sedentary

Alcohol: ⁪ None ⁪ Occasional ⁪ Daily \_\_\_\_\_\_\_\_\_\_drinks/week

Smoking: ⁪ None ⁪ Occasional ⁪ Daily \_\_\_\_\_\_\_\_\_packs/day ⁪ I want to quit.

**Have you ever had, or been diagnosed with:**

Cancer\_\_\_\_\_ Heart attack\_\_\_\_\_

Had a spine surgery or spinal cord injury\_\_\_\_ High cholesterol\_\_\_\_

Fracture or broken bone\_\_\_\_ High blood pressure\_\_\_\_

Diabetes/ pre-diabetes\_\_\_\_ Carotid artery sentosis\_\_\_\_

Stroke\_\_\_\_ Polycystic ovarian syndrome\_\_\_\_

**Have you experienced:**

⁪ ongoing fatigue\_\_\_\_\_ freguent urination\_\_\_\_\_

⁪ blurry vision \_\_\_\_\_ frequent feeling of thirst\_\_\_\_\_

⁪ tinnitus / ringing in ears\_\_\_\_\_ frequent infections\_\_\_\_\_

⁪ unexplained weight loss / gain \_\_\_\_\_ numbness/tingling in hands or feet\_\_\_\_\_

**⁪**

**The above information is true, complete and accurate to the best of my knowledge.**

**Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**