Confidential Practice Member Information

This form can either be completed online or you can print a hard copy and return it by post or email.

PRINT FORM

Please note: for the best experience, it is recommended to download this interactive form to your device and use Adobe Acrobat Reader to view and fill in. Acrobat Reader is a free pdf viewer and is available to download for Mac, PC, iOS, Android and Windows Phone here: https://www.adobe.com/uk/acrobat/pdf-reader.html

Today's Date: _____

First Name: _____ Middle Initial: _____ Surname: _____

Date of birth: _____ Age: _____ Sex: ◯ M ◯ F

Home Phone Number: _____ Work Number: _____ Mobile: _____

Home Address: _____

City/Town: _____ County: _____ Postcode: _____

Email Address: _____

Occupation: _____ Previous Occupation: _____

Marital Status: ◯ Married/Partnered ◯ Single ◯ Widowed ◯ Separated ◯ Divorced

Partner's Name (if applicable) _____

Names and ages of children _____

How did you find about this practice? _____

Whom may we thank for referring you to this office? _____

Have you ever had your spine or nervous system examined professionally? ◯ Yes ◯ No

If yes, when and by whom? _____

Have you received previous chiropractic care? ◯ Yes ◯ No

If yes, when and by whom? _____

Health objectives/reasons for consulting our office (tick any that apply)

☐ Maximizing personal health potentials

☐ Preventing disease, symptoms, infirmities

☐ Symptoms, disease, infirmities

As a full spectrum wellness-based chiropractic office, we focus on your ability to be healthy. Our goals are firstly: to address the issues that brought you to this office, and then provide you with the opportunity to improve your health and wellbeing.

Current health issues

What concerns do you currently have about your health? Briefly describe the area that is most intolerable and include the effect it has had on your life.

What does it feel like? _____

When did you first detect this? _____

Since it started, is it: ◯ the same ◯ better ◯ worse ◯ constant?

What makes it worse? _____

What have you tried to make it tolerable? _____

Have you had any traumas, accidents (physical, emotional, chemical) that is related to your health concern?

_____

Any other traumas, accidents not already mentioned? _____

Does it stop you from doing anything in your life? _____

Does it affect your sleep? _____ Do you feel alert after a night's sleep? _____

How long has it been since you felt really well? _____

Other medics/healthcare professionals/therapists you have seen for this and what was done?

_____

How would you describe your

Diet	◯ Poor	◯ Good	◯ Excellent	Stress level	◯ Poor ◯ Good ◯ Excellent
Rest	◯ Poor	◯ Good	◯ Excellent	Immune system	◯ Poor ◯ Good ◯ Excellent
Exercise	◯ Poor	◯ Good	◯ Excellent	How often do you get sick each year?	_____

Have you experienced any of these stressful situations? Please check either **P**ast or **C**urrent.

	Mild	Moderate	Severe		Mild	Moderate	Severe
Childhood stress	☐P ☐C	☐P ☐C	☐P ☐C	Work-related stress	☐P ☐C	☐P ☐C	☐P ☐C
School stress	☐P ☐C	☐P ☐C	☐P ☐C	Commuting stress	☐P ☐C	☐P ☐C	☐P ☐C
Family stress	☐P ☐C	☐P ☐C	☐P ☐C	Loss of a loved one	☐P ☐C	☐P ☐C	☐P ☐C
Personal relationship	☐P ☐C	☐P ☐C	☐P ☐C	Lifestyle change	☐P ☐C	☐P ☐C	☐P ☐C
Stress of being sick	☐P ☐C	☐P ☐C	☐P ☐C	Abuse	☐P ☐C	☐P ☐C	☐P ☐C

Past Health History
The practice of chiropractic is based on the location and correction of nervous system interference and tension. The interferences are caused by any stress your body cannot properly perceive, adapt to or recover from. These stresses may be physical, chemical or emotional in nature. The following sections will give the chiropractor information as to how long your body may have been tolerating these stresses before you may have been aware of them.

Physical History
Birth stress: was your mother ill during pregnancy? _____

Do you know anything about your birth?

_____

Have you (had) …

Ever been knocked unconscious	◯ Yes, if so, when? _____	◯ No
Any broken bones/fractures	◯ Yes, if so, when? _____	◯ No
Ever been hospitalised	◯ Yes, if so, when? _____	◯ No
Any surgery/operations	◯ Yes, if so, when? _____	◯ No
Any car accidents	◯ Yes, if so, when? _____	◯ No

Chemical History
List all chemicals you are taking and their purpose (include ALL prescriptive and non-prescriptive drugs such as birth control, aspirin etc.)

Have you ever had radiation or chemotherapy? _____

Have you ever had any reactions to medications or vaccinations? _____

Do you have any allergies? (please list)

How often do you consume the following? (please select from never, daily, weekly, monthly, or sometimes)

Alcohol _____ Coffee _____

Tea _____ Artificial sweeteners _____

Carbonated drinks _____ Refined sugar _____

Meat _____ Dairy _____

Wheat _____ Cigarettes _____ No. per day _____

Daily water intake _____

Do you take any vitamins, mineral supplements? (please list)

Family History
Is there any family history of the following? If so, please describe.

Cancer _____

Diabetes _____

Heart Disease/Stroke _____

Autoimmune Disease _____

Please add anything else you may feel is significant.

Consent to Examination
I consent to a physical examination. To be signed in person at your consultation.

Signed | Date

If under the age of 16, Parent / Guardian signed | Date

Please tick to indicate your consent and opt in

☐ I understand my records will be held on file for eight years after my last appointment with Vibrant World Chiropractic (or until a child reaches 25 years old) and this is a legal requirement.

☐ Yes, please remind me of upcoming appointments via email or text.

☐ I would like to be told about upcoming events at and news of Vibrant World Chiropractic via email and occasionally by post.

Thank you for choosing our office. We are looking forward to helping you take back control of your health. We are excited at the possibility of assisting you and your family on your journey towards staying well and feeling alive!

Important! After completing the form: **1. Save your form** and then: **2. Click the 'SUBMIT FORM' button** below.

If you are filling in by hand, please scan your completed form and email to info@vibrantworld.co.uk. Alternatively, return by post to Vibrant World Chiropractic, at Castle Street Clinic, 36-37 Castle Street, Guildford, Surrey, GU1 3UQ

You can also use the **'PRINT FORM' button** to print a copy for your own records, if you wish.

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