

**BodyBalance Chiropractic**  
25 Marshland Road, Christchurch

**Confidential Health History**

Please complete this questionnaire. Your answers will determine if chiropractic can help you. Your health history is important to us in accepting your case.

First name \_\_\_\_\_ Surname \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Phone home \_\_\_\_\_  
GP \_\_\_\_\_ work \_\_\_\_\_  
Marital Status \_\_\_\_\_ mobile \_\_\_\_\_  
Address \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

What is your main concern (why are you here today)? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you had this before? \_\_\_\_\_ If so, when? \_\_\_\_\_

Did the problem come on gradually or suddenly? \_\_\_\_\_

Was your problem the result of an accident? \_\_\_\_\_

If so, how did it happen? \_\_\_\_\_

Have you noticed any loss of strength or feeling as a result of your problem? \_\_\_\_\_

If so, where? \_\_\_\_\_

Do you get pins/needles or numbness in your hands/feet? \_\_\_\_\_

Have you noticed anything makes the problem feel:

Better \_\_\_\_\_

Worse \_\_\_\_\_

If you are in pain what description best describes your pain (please circle)?

Stabbing      dull/achy      burning      tension      stiffness      electric  
Shock

Who else have you seen for this problem (e.g. GP)? \_\_\_\_\_

Drugs/medication you take now? \_\_\_\_\_

\_\_\_\_\_  
\_Vitamins/minerals you take now?

\_\_\_\_\_  
Think you may need vitamins or minerals? \_\_\_\_\_

List surgical operations and when \_\_\_\_\_

\_\_\_\_\_  
\_List major accidents and when \_\_\_\_\_

\_\_\_\_\_  
\_Do you drink alcohol? \_\_\_\_\_ How often?

\_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How many cigarettes per day? \_\_\_\_\_

Have you suffered from a mental or emotional illness (if so please describe)? \_\_\_\_\_

\_\_\_\_\_

Please tick next to any of the following symptoms which you have now. Underline those symptoms you have had in the past. We want to know all the facts about your health before we accept your case. THIS INFORMATION IS CONFIDENTIAL.

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**General**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Unexplained loss of weight
- Anxiety/depression
- Neuralgia
- Numbness
- Tremors
- Rash

**Gastrointestinal**

- Belching/Gas
- Colitis
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Poor appetite
- Vomiting
- Vomiting blood

**Cardiovascular**

- Hardening of the arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**Respiratory**

- Chest pain
- Chronic cough
- Difficulty breathing
- Wheezing

Asthma

**Muscle and Joint**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Neck pain/stiffness
- Pain between shoulder blades
- Spinal curvature/scoliosis

**Ears, Nose & Throat**

- Colds
- Deafness
- Earache
- Ear discharge
- Ringing in ears
- Enlarged glands
- Enlarged thyroid
- Eye pain

Hay fever

**Genito-urinary**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control urination
- Kidney infection/stones
- Painful urination
- Prostate trouble
- Pus in urine

**Pain or Numbness**

- Shoulders
- Arms
- Hands
- Hips
- Legs
- Feet
- Sciatica
- Spinal curvature
- Swollen joints

**Failing vision**

- Failing vision
- Tonsillitis
- Nasal obstruction
- Nose bleeds
- Sinus infection
- Sore throat
- Ulcers

**For Women Only**

- Cramps or backache
- Excessive menstrual flow
- Hot flushes
- Irregular cycle
- Lumps in breast
- Menopausal symptoms
- Painful menstruation
- Pre-menstrual symptoms

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Tick the following conditions you have had:

- |                                    |                                          |                                             |                                        |
|------------------------------------|------------------------------------------|---------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Ulcers        |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Glandular fever | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Goitre          | <input type="checkbox"/> Pleurisy           |                                        |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Gout            | <input type="checkbox"/> Polio              |                                        |

I voluntarily disclose the above as a true and accurate record of my past Health and Medical History and have not withheld any relevant information. I consent to a complete chiropractic examination. I understand that any fee for service rendered is due at the time of treatment and cannot be deferred to a later date.

Signed \_\_\_\_\_ Date \_\_\_\_\_