DEBORAH BEN-SHAH, D.C.

move better to feel better

Adult New Patient Medical History

Surname: Age:

Forename(s): Preferred Name: DOB:

Address:

Home Tel: Work Tel:

Mobile: Email:

Occupation:

Marital Status: S M D W Partners Name:

Names of Children & Ages

Name and Practice of GP

Have you ever received Chiropractic care? ☐ Yes ☐ No Please tick

Why are you here?

How did you hear about us

Your body is designed to be healthy. There is always a cause or reason to why it is not. Throughout life many events occur that may damage your health.

The following questions will help us assess any layers of damage, particularly to your nervous system, that have adversely affected your health. All information will be handled in the strictest of confidence. Please tick where appropriate.

Your Birth

The birth process can be quite traumatic on both mother and baby and is often where spinal damage may first occur. Was your birth:

☐ Unassisted ☐ Forceps/Suction ☐ Caesarean ☐ Short duration
☐ Premature ☐ Induced ☐ Breech ☐ Drug assisted
☐ Prolonged labour ☐ Unsure

Your Childhood

Children often display symptoms of decreased health that may stem from spinal problems and/or nerve pressure. As a child did you suffer from:

☐ Colic ☐ Bedwetting ☐ Ear Infections ☐ Mumps
☐ Allergies ☐ Asthma ☐ Eczema ☐ Measles
☐ Chicken Pox ☐ German Measles ☐ Tonsillitis/throat infection ☐ Other

As a child were you:

☐ Breast fed ☐ A restless sleeper ☐ A head banger

As a child did you:

☐ Have any major accidents ☐ Have surgery ☐ Require medication (prescribed/other)
☐ Crawl before walking ☐ Use a baby walker ☐ Use a baby bouncer
☐ Sleep on your stomach ☐ Fall down stairs ☐ Use calipers
☐ Have flat feet ☐ Have turned feet ☐ Have a chair pulled from under you

Were you vaccinated as a child: ☐ yes ☐ no ☐ unsure

Women Only

Reproductive issues can place a strain on your body's resources. Chiropractic can help redress the balance. Have you had/Do you have:

☐ Period pain/discomfort ☐ PMT ☐ Irregular period's ☐ Chronic thrush

Have you experienced any fertility problems (please give details)?_____
_____

Number of full term pregnancies _____ Number of pregnancies not to term _____

Have you experienced any problems throughout pregnancy (please explain) or with the birth (give details_____
_____
_____

Have you been on the oral contraceptive pill? yes ☐ for how long _____ no ☐

Accidents

Have you ever suffered:

☐ Broken bones Age_____ ☐ Motor vehicle accidents Age_____
☐ Sprains Age_____ ☐ Fainting/Unconsciousness Age_____
☐ Other Age _____

Please give details: _____
_____
_____
_____

As the core problems get coated with more and more layers of damage, symptoms and bouts of sickness arise, displaying decreasing adaptability and health.

General Health

Have you ever suffered from an illness that required hospitalisation or long-term medication?

Describe_____
_____Age _____

Do you take any medication/drugs (prescription/non prescription)

Medication:_____ What for _____ How long?_____
Medication:_____ What for _____ How long?_____
Medication:_____ What for _____ How long?_____
Medication:_____ What for _____ How long?_____

Have you ever had surgery either as a child or an adult?

☐ Tonsils ☐ Appendix ☐ Adenoid's ☐ Hysterectomy
☐ Other (please give details) _____
_____

Have you ever had x-rays, scans or MRI (Please give dates and details)?_____
_____

Have you had/Do you have:

☐ Headaches	☐ Chest pains	☐ Cold sweats
☐ Cystitis/bladder infections	☐ Dizziness	☐ Palpitations
☐ Loss of balance	☐ Loss of consciousness	☐ Eye problems
☐ Heart attacks/angina	☐ Loss of smell/taste	☐ Arthritis/joint swelling
☐ Loss of vision	☐ High blood pressure	☐ Diabetes
☐ Difficulty breathing	☐ Hearing problems	☐ Low blood pressure
☐ Jaw pain/clicking	☐ Asthma	☐ Strokes/T.I.A.'s
☐ Varicose veins	☐ Teeth grinding	☐ Sinus problems
☐ Pins and needles	☐ Fatigue/tiredness	☐ Orthodontic work
☐ Allergic reactions	☐ Numbness	☐ Diarrhoea & constipation
☐ Teeth removed	☐ Eczema/skin problems	☐ Indigestion
☐ Cancer	☐ Prostate problems	☐ Epilepsy/fits/seizures
☐ Swelling of ankles	☐ Rapid weight loss	☐ Difficulty urinating
☐ Other		

Do you suffer with:

☐ Occupational Stress ☐ Physical stress ☐ Mental stress

Nutrition

Do you:

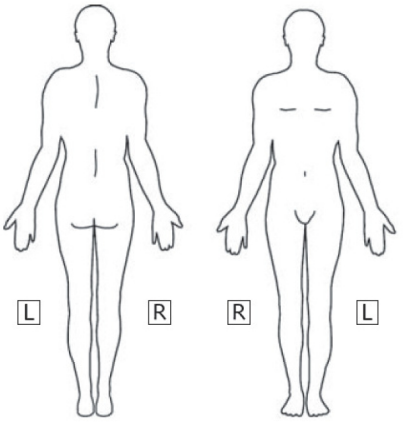
Smoke: ☐ yes ☐ no Number per day? _____
Drink alcohol: ☐ yes ☐ no Glasses (not pints) per week? _____
Drink water: ☐ 0-1 glass per day ☐ 1-3 glasses per day ☐ 4-8 glasses per day ☐ more

Eat *fresh* vegetables: ☐ 0-3 servings per week ☐ at least 1 per day ☐ several per day
Eat *fresh* fruit: ☐ 0-3 servings per week ☐ at least 1 per day ☐ several per day

Is there a family history of:

	Heart disease	Arthritis	Cancer	Diabetes	Other
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐

Are you suffering any pain or illness conditions at the moment?
Describe them and indicate areas on the diagrams



Indicate on the following scale how you would rate your pain/discomfort on a scale of 1-10:

1 No Pain — 10 Extreme Pain

Which sports, hobbies or leisure activities do you engage in: _____

What is your sleeping posture? ☐ Side ☐ Stomach ☐ Back

Number of hours of quality sleep per night _____

How many pillows do you use?_____ How old is your mattress? _____

On a scale of 1 – 10 how would you rate your health?

1 Poor — 10 Excellent

Reasons:_____

Do you have Health Insurance?
If "Yes", please provide your policy details _____