Sensus
HEALTH & WELLNESS

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 Sensus Health & Wellness?

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

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

As a child were you:

☐ Breast fed ☐ A restless sleeper ☐ A head banger

As a child did you:

☐ Have any major accidents
☐ Crawl before walking
☐ Sleep on your stomach
☐ Have flat feet
☐ Have surgery
☐ Use a baby walker
☐ Fall down stairs
☐ Have turned feet
☐ Require medication (prescribed/other)
☐ Use a baby bouncer
☐ Use calipers
☐ 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______
☐ Sprains Age______
☐ Other Age ______
☐ Motor vehicle accidents Age______
☐ Fainting/Unconsciousness 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
☐ Cystitis/bladder infections
☐ Loss of balance
☐ Heart attacks/angina
☐ Loss of vision
☐ Difficulty breathing
☐ Jaw pain/clicking
☐ Varicose veins
☐ Pins and needles
☐ Allergic reactions
☐ Teeth removed
☐ Cancer
☐ Swelling of ankles
☐ Other
☐ Chest pains
☐ Dizziness
☐ Loss of consciousness
☐ Loss of smell/taste
☐ High blood pressure
☐ Hearing problems
☐ Asthma
☐ Teeth grinding
☐ Fatigue/tiredness
☐ Numbness
☐ Eczema/skin problems
☐ Prostate problems
☐ Rapid weight loss
☐ Cold sweats
☐ Palpitations
☐ Eye problems
☐ Arthritis/joint swelling
☐ Diabetes
☐ Low blood pressure
☐ Strokes/T.I.A.'s
☐ Sinus problems
☐ Orthodontic work
☐ Diarrhoea & constipation
☐ Indigestion
☐ Epilepsy/fits/seizures
☐ Difficulty urinating

Do you suffer with:

☐ Occupational Stress ☐ Physical stress ☐ Mental stress

Nutrition

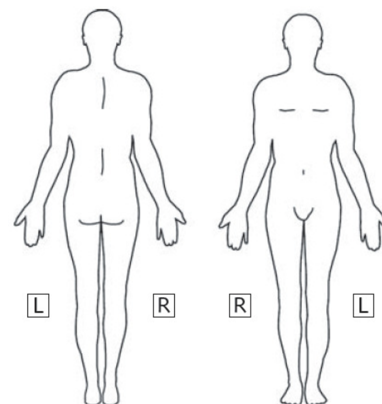
Do you:
Smoke: ☐ yes ☐ no Number per day? ______
Drink alcohol: ☐ yes ☐ no Glasses (not pints) per week? ______
Drink water: ☐ 0-1 glass per day ☐ 1-3 glasses per day ☐ 4-8 glasses per day ☐ more

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:

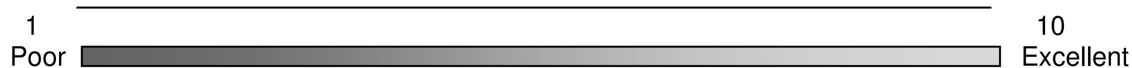
Which sports, hobbies or leisure activities do you engage in: ______________________________

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?



Reasons:______________________________