



PETERBOROUGH
CHIROPRACTIC
HEALTH & WELLNESS GROUP

Welcome to Peterborough Chiropractic

At Peterborough Chiropractic it is our mission to help you achieve all your health goals and needs.

Whether your main reason for seeing us is to lose weight, get out of pain, increase your energy or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess and to gain an accurate understanding of where the root cause of your symptoms lie, we will be taking you through a series of examinations on your initial visit. This will include a full case history, orthopaedic and neurological assessment, postural analysis, and a functional movement assessment. These are all non-invasive and nothing to worry about we promise! Please be aware if further testing is required such as X-ray, MRI or Blood work, this will be determined by the doctor on the day and arranged by the team.

Getting ready for your visit, on the day we ask that you wear fitted clothing and something you are comfortable moving in for the physical portion of the examination, in addition to this if you have any previous X-rays or MRI reports please bring these along with you on the day for our record if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take between 30 – 40 minutes so we ask you allow sufficient time and if you have any concerns please speak to our reception before your visit if time is a constraint.

PLEASE NOTE:

We do enforce a 24-hour cancellation policy where the full fee will be charged if prior notice has not been given. If you are running late, you do run the risk of our Doctor being unable to see you, in this scenario please contact our reception staff on 01733 555 568



On the diagram above:-

A. What number do you think represents your health today? _____

B. In what direction is your health currently heading? _____

Have you had any spinal x-rays taken in the last 12 months? No Yes

Please state any major illnesses or any surgeries and years: _____

List traumas (Car-whiplash/home/sports/work injuries etc.) and years: _____

Family Health Profile:

At Peterborough Chiropractic we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones.

Do you or any of your family suffer from?

Diabetes Heart problems Stroke Epilepsy Cancer Orthopaedic Problems

Please mention below any other health conditions or concerns you may have about family members:-

Children Spouse Mother Father Brothers Sisters Others

Female Clients:-

Are you currently pregnant? No Yes, I am due _____ Number of past pregnancies? _____

Have you any health concerns regarding this pregnancy? _____

Allergies, Medications & Supplements

Allergies (list)

Medications (list)

Supplements (list)

DECLARATION: This information is accurate to the best of my knowledge. My signature below will also serve as consent for any examination procedures deemed appropriate/necessary by the chiropractor.

Signature: (parent/guardian to sign for minors): _____

Date: _____



Medical Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for : Past 30 days Past 48 hours

Point Scale: 0- Never or almost never have the symptom. 1- Occasionally have it, effect is not severe.

2- Occasionally have it, effect is severe. 3- Frequently have it, effect is not severe. 4 – Frequently have it, effect is severe.

<p><u>HEAD</u></p> <p>___ Headaches</p> <p>___ Faintness</p> <p>___ Dizziness</p> <p>___ Insomnia</p> <p style="text-align: right;">Total: ___</p>	<p><u>ENERGY / ACTIVITY</u></p> <p>___ Fatigue/ Sluggishness</p> <p>___ Apathy / Lethargy</p> <p>___ Hyperactivity</p> <p>___ Restlessness</p> <p style="text-align: right;">Total: ___</p>	<p><u>LUNGS</u></p> <p>___ Chest Congestion</p> <p>___ Asthma, Bronchitis</p> <p>___ Shortness of breath</p> <p>___ Difficulty breathing</p> <p style="text-align: right;">Total: ___</p>
<p><u>EYES</u></p> <p>___ Watery or Itchy eyes</p> <p>___ Swollen, reddened or sticky eyelids</p> <p>___ Bags or dark circles under eyes</p> <p>___ Blurred or tunnel vision</p> <p>(Does not include near or far sighted)</p> <p style="text-align: right;">Total: ___</p>	<p><u>WEIGHT</u></p> <p>___ Binge eating / Drinking</p> <p>___ Craving certain foods</p> <p>___ Excessive weight</p> <p>___ Compulsive eating</p> <p>___ Water retention</p> <p>___ Underweight</p> <p style="text-align: right;">Total: ___</p>	<p><u>HEART</u></p> <p>___ Irregular or skipped heartbeat</p> <p>___ Rapid or pounding heartbeat</p> <p>___ Chest pain</p> <p style="text-align: right;">Total: ___</p>
<p><u>EARS</u></p> <p>___ Itchy ears</p> <p>___ Earaches / Ear infections</p> <p>___ Drainage from ears</p> <p>___ Ringing in ears / Hearing loss</p> <p style="text-align: right;">Total: ___</p>	<p><u>EMOTIONS</u></p> <p>___ Mood swings</p> <p>___ Anxiety / Fear / Nervousness</p> <p>___ Anger / Irritability / Aggressiveness</p> <p>___ Depression</p> <p style="text-align: right;">Total: ___</p>	<p><u>DIGESTIVE TRACT</u></p> <p>___ Nausea / Vomiting</p> <p>___ Diarrhoea</p> <p>___ Constipation</p> <p>___ Bloating feeling</p> <p>___ Belching / Passing gas</p> <p>___ Heartburn</p> <p>___ Intestinal / Stomach pain</p> <p style="text-align: right;">Total: ___</p>
<p><u>NOSE</u></p> <p>___ Stuffy nose</p> <p>___ Sinus problems</p> <p>___ Hay fever</p> <p>___ Sneezing attacks</p> <p>___ Excessive mucus Formation</p> <p style="text-align: right;">Total: ___</p>	<p><u>MIND</u></p> <p>___ Poor memory</p> <p>___ Confusion / Poor comprehension</p> <p>___ Poor concentration</p> <p>___ Poor physical condition</p> <p>___ Difficulty in making decisions</p> <p>___ Stuttering / Stammering</p> <p>___ Slurred speech</p> <p>___ Learning disabilities</p> <p style="text-align: right;">Total: ___</p>	<p><u>OTHER</u></p> <p>___ Frequent illness</p> <p>___ Frequent or urgent urination</p> <p>___ Genital Itch or discharge</p> <p style="text-align: right;">Total: ___</p>

<u>MOUTH / THROAT</u>	<u>SKIN</u>	<u>JOINTS / MUSCLE</u>
___ Chronic coughing	___ Acne	___ Pain or Aches in joints
___ Gagging / Frequent need to clear throat	___ Hives / Rashes / Dry Skin	___ Arthritis
___ Sore throat / Hoarseness / Loss of voice	___ Hair loss	___ Stiffness or limited movement
___ Swollen or discoloured tongue / Gums / Lips	___ Flushing / Hot flashes	___ Pain or Aches in Muscles
___ Canker sores	___ Excessive sweating	___ Feeling of weakness or tiredness
Total:___	Total:___	Total:___
GRAND TOTAL:_____		

I authorise Peterborough Chiropractic to contact me by the following,

I am aware I can opt out at any time, please initial to opt IN for the following:

- Letter _____
- Telephone _____
- Email _____
- Social Media _____

I am happy to continue chiropractic treatment, at the following schedule

Sign..... Date.....

Office use only



Health Satisfaction assessment

Name: _____ **Date:** _____

Email address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

Physical Health:

I am a physically fit person and formally exercise on a regular basis. 1 2 3 4 5 6 7 8 9 10

I have a physically attractive body that I am proud to look at in the mirror. 1 2 3 4 5 6 7 8 9 10

I have not had any traumas in my life (auto accident, broken bones, bad falls). 1 2 3 4 5 6 7 8 9 10

I get at least 7 hours of sleep a night, 7 days a week. 1 2 3 4 5 6 7 8 9 10

I have had regular Chiropractic care within the past 5 years. 1 2 3 4 5 6 7 8 9 10

Total: _____

Emotional Health:

I am a calm, peaceful person. I can shut my mind off and focus my mind at will. 1 2 3 4 5 6 7 8 9 10

I can practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis. 1 2 3 4 5 6 7 8 9 10

Most of the time, I am truly happy and feel some sense of purpose in my life. 1 2 3 4 5 6 7 8 9 10

I have healthy relationships and a rich social network of friends and activities. 1 2 3 4 5 6 7 8 9 10

I am organised, have time for myself, and can prioritise the important tasks in my life. 1 2 3 4 5 6 7 8 9 10

Total: _____

Chemical / Nutritional Health:

I eat 4 – 6 small meals daily and properly combine my protein, carbs and fats. 1 2 3 4 5 6 7 8 9 10

I supplement everyday with good supplements such as vitamin/ mineral complex, antioxidants and good fatty acids (fish oil, flax seeds etc). 1 2 3 4 5 6 7 8 9 10

I do not take medications for chronic medical problems such as digestive disorders, cardiovascular problems, headaches, chronic pain, blood sugar problems, chronic fatigue, immune problems or chronic infections, or any other chronic conditions. 1 2 3 4 5 6 7 8 9 10

I do not smoke cigarettes. 1 2 3 4 5 6 7 8 9 10

I drink water as my primary beverage and consume at least 2 litres a day. 1 2 3 4 5 6 7 8 9 10

TOTAL: _____

Total of all 3 (Physical, Emotional and Chemical) sections: _____