Chiropractic Initial Health & Wellbeing Intake Form

Chiropractic Centre

Section 1: Personal Information

To help us understand who you are and how to best support your health goals

Full Name:

Preferred Name:

Age:

Date of Birth:

Occupation: _____

◯ Sedentary ◯ Light ◯ Heavy

Home Address:

Mobile:

Email address:

NHI # (if known):

Iwi affiliation (if applicable):

Ethnicity (tick all that apply):

◯ Māori ◯ NZ European/Pākehā ◯ Pasifika ◯ Asian
◯ Middle Eastern ◯ Latin American ◯ African ◯ Other: _____

Pronouns:

◯ He/Him
◯ She/Her
◯ They/them
◯ Other
◯ Prefer to self-describe
_____

Gender Identity:

◯ Male
◯ Female
◯ Non-binary
◯ Gender diverse
◯ Prefer to self-describe
_____

Sex at birth (if relevant to care):

◯ Male
◯ Female
◯ Intersex
◯ Prefer to self-describe
_____

Emergency contact (please provide name, relationship and phone number):

How did you hear about us? _____

Chiropractic Intern Name: _____

Patient (please provide name so that we can thank them): _____

CONSENT TO SHARE OF INFORMATION

New Zealand College of Chiropractic is an educational institution. At times, patient files may need to be discussed between Chiropractic Centre Mentors and Interns to ensure that you receive optimum care. Year 1-3 Chiropractic Students are required to observe so may be present during your visit.

From time to time the College takes photographs of staff, mentors, patients and students to record activities within the College. These photos will be used responsibly, and measures will be taken to avoid personal identification. Please advise the College if you have any concerns about publication of your photos.

Video assessments may be used for the purposes of teaching and ongoing training. Videos are not made public, and patients are not identified.

Data collection may take place through student evaluations, patient feedback, and patient records for research purposes. Individuals will not be identified. This research may be published and held by the College in perpetuity. The supply of the information is voluntary except where required for funding and/or government reporting purposes.

I have reviewed read and understand the Share of Information above.

Signature: _____ Date: ____ / ____ / _____

Office Use Only:

CA Signature: _____ Date: ____ / ____ / _____

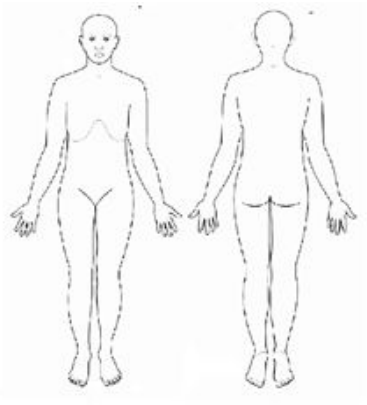
Intern initials: _____ Mentor initials: _____

Section 2: Your Health Story

What brings you in today?

- ◯ Relief from a health concern
- ◯ Maintaining/improving wellness
- ◯ Both the above
- ◯ Result of an accident/injury

Please describe your main concerns (use image to locate):



_____
_____
_____
_____
_____
_____

How do you feel your overall health is at present?

◯ Excellent
◯ Good
◯ Fair
◯ Poor

What is most important to you regarding your health and wellbeing?

_____
_____

Section 3: Key Health Indicators

These questions help us identify the safest way to deliver your chiropractic care

Please tick if you have, or have ever had:

- ◯ Unexplained weight loss, fever, or night pain or sweats
- ◯ History of cancer
- ◯ Trauma, incidents, accident, or fracture
- ◯ Osteoporosis or bone disease
- ◯ Numbness, tingling, or weakness in arms/leg
- ◯ Loss of bladder or bowel control
- ◯ Severe dizziness or fainting
- ◯ Difficulty speaking, swallowing, or vision changes
- ◯ Heart disease, stroke, or blood clotting disorder
- ◯ Headaches/migraines
- ◯ Any other health condition we should know about: _____
- ◯ **I don't have or have never had any of the above**

Are you currently pregnant?	◯ Yes	◯ No	◯ Unsure
Have you been pregnant?	◯ Yes	◯ No	◯ Unsure
Are you currently trying to get pregnant?	◯ Yes	◯ No	◯ Unsure
Is your menstrual cycle:	◯ Painful	◯ Heavy	◯ Irregular

What medications and/or supplements are you currently taking?

Please add any previously taken for a substantial amount of time

Medications/Supplements	Reason

◯ **I am not taking any medications or supplements**

Section 4: Current Health & Lifestyle Snapshot

There are several causes which contribute to your nervous system being challenged in some capacity. These questions help us identify some potentials.

Please rate or describe – this helps us focus on strengths and areas to support

Energy & Vitality (0 = always tired, 5 = full of energy): 0 1 2 3 4 5

Sleep quality (0 = poor, 5 = excellent): 0 1 2 3 4 5

Stress levels: Low Moderate High

Physical activity/exercise/sports/hobbies:

Type(s): _____ Frequency: _____

Type(s): _____ Frequency: _____

Type(s): _____ Frequency: _____

Nutrition and hydration:

How would you rate your current **eating** and **drinking** habits?

Eating: ◯ Excellent ◯ Good ◯ Fair ◯ Needs improvement

Water intake: Frequency _____/day

Alcohol intake: Frequency _____/day

Caffeine intake: Frequency _____/day

Do you smoke or vape? ◯ No ◯ Yes

Mental & Emotional Wellbeing:

What helps you manage stress or stay positive? _____

Social & Whānau Connections:

Who supports you in your health/wellbeing journey? _____

Section 5: Health & Family History

Past surgeries/Hospitalisations/Major illnesses/Injuries/Accidents and dates:

_____

_____

_____

_____

_____

◯ **I have never had any of the above**

Have you ever been diagnosed with or received support for:

◯ Anxiety
◯ Depression
◯ Other mental health condition: _____
◯ Prefer not to say

Childhood Health Issues:

◯ Broken bones ◯ Accidents ◯ Falls ◯ Head trauma ◯ Serious illness ◯ Asthma ◯ Allergies
◯ Neurodivergent diagnosis

_____

_____

_____

Close family history (tick any):

◯ Heart disease ◯ Cancer ◯ Stroke ◯ Diabetes ◯ Arthritis ◯ Other: _____

Section 6: Other Health Providers

Have you previously received Chiropractic care?

◯ Yes ◯ No If yes, with whom: _____

What style of care was it? ◯ Manual ◯ Low Force ◯ Instrument based

Was it helpful? ◯ Yes ◯ No

Have you previously had any imaging or lab tests performed (X-rays/MRI/Scans) ?

◯ Yes ◯ No

If yes, please list:

_____

_____

Are you currently receiving care from another health professional?

◯ Yes ◯ No

If yes, please list: _____ (e.g. GP, physio, counsellor, specialist, naturopath)

Section 7: Your Goals for Care

What aspects of your health are top priorities right now?

_____

_____

_____

What activities or lifestyle changes would you like to return to or improve?

_____

_____

_____

With chiropractic care, my goals are: (Tick all that apply)

◯ Improved function/performance
◯ Better posture/movement
◯ Pain relief
◯ More energy & vitality
◯ Family/whānau wellness
◯ Other: _____

Review of Information & Consent to Examination

I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge. I understand that I may be asked to perform a physical examination and assessment of nervous system dysfunction where appropriate, (including imaging if required) and the risks and benefits will be explained to me.

Signature: _____ Date: ____ / ____ / _____