

# Active Chiropractic Confidential Practice Member Information

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Street City Country Postal Code

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Mobile ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_ (confidential)

Do you wish to receive our newsletter through email on the latest health tips on wellness, nutrition and exercise? Y N

IC or Passport # \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

No. of children \_\_\_\_\_ Pregnant? \_\_\_\_\_ Marital Status: M S W D

Spouse/Guardian Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_ Spouse Occupation/Employer \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

## I. HEALTH CONCERNS

List health concerns Accordingly to their severity	Rate of severity 1= mild 10= worst imaginable	How many weeks, months, years you have had problem	% of time pain is present	1 <sup>st</sup> time you had problem (Y/N)
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Is this concern interfering with your: work \_\_\_\_\_ sleep \_\_\_\_\_ daily routine \_\_\_\_\_ sports/exercise \_\_\_\_\_ quality family time \_\_\_\_\_ other \_\_\_\_\_

What activities aggravate your concern/condition? \_\_\_\_\_

What have you done for this concern/condition: Chiropractor \_\_\_\_\_ Medical Dr. \_\_\_\_\_ TCM \_\_\_\_\_ Orthopedic \_\_\_\_\_

Surgical Consult \_\_\_\_\_ Physiotherapy \_\_\_\_\_ Other \_\_\_\_\_

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

\_\_\_\_\_

\_\_\_\_\_

Are you unable to do certain activities that you would like to do because of this pain, illness, concern? (i.e. sports, walk, pick up children/grandchildren, etc.) If so, what?

**Have you had any surgery? (Please include all surgery)**

- 1. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 2. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 3. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 4. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

**Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).**

- 1. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

**II. CURRENT MEDICINE/ PAST HISTORY**

**Please list ALL drugs you currently take or have taken in the past 6 months:**

- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Others \_\_\_\_\_

**Please list all nutritional supplements, vitamins, homeopathic remedies you presently take:**

- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_
- Others \_\_\_\_\_

**Mark the following conditions you may have had or have now (- have had + have now)**

- \_\_\_ Allergy      \_\_\_ Diarrhea      \_\_\_ Measles      \_\_\_ Alcoholism      \_\_\_ Eczema      \_\_\_ Miscarriage
- \_\_\_ Stroke      \_\_\_ Anemia      \_\_\_ Multiple Sclerosis      \_\_\_ HIV (AIDS)      \_\_\_ Gout
- \_\_\_ Arteriosclerosis      \_\_\_ Emphysema      \_\_\_ Mumps      \_\_\_ Sinus Problems      \_\_\_ Arthritis      \_\_\_ Neuritis
- \_\_\_ High Blood Pressure      \_\_\_ Asthma      \_\_\_ Nervousness      \_\_\_ Thyroid Problems      \_\_\_ Ulcers      \_\_\_ Cancer
- \_\_\_ Heart Disease      \_\_\_ Depression      \_\_\_ Constipation      \_\_\_ Pneumonia      \_\_\_ Cold Sores      \_\_\_ Polio

Neck Pain     Gall Bladder Problems     Migraines     Headaches     Menstrual Cramps  
 Back Pain     Irregular Periods     Diabetes     Heart Attack     Low Blood Sugar  
 Ringing in ears     Other (please explain)\_\_\_\_\_

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**General Emotional Trauma:**

With each of the following stress situations, please write either "P" for past or "C" for current:

	Mild	Moderate	Severe		Mild	Moderate	Severe
Childhood stress	___	___	___	Work related stress	___	___	___
School stress	___	___	___	Stress of commuting	___	___	___
Loss of loved one	___	___	___	Taking care of sick Family member	___	___	___
Family stress	___	___	___	Change in lifestyle	___	___	___
Personal relationship	___	___	___	Change in job	___	___	___
Stress of being sick	___	___	___	Financial	___	___	___

How many hours do you sleep/night? \_\_\_\_\_

How do you grade your physical health?    Excellent\_\_\_    Good\_\_\_    Fair\_\_\_    Poor\_\_\_    How often/week do you exercise? \_\_\_\_\_

How do you grade your emotional/mental health?    Excellent\_\_\_    Good\_\_\_    Fair\_\_\_    Poor\_\_\_

Any reason that you would not be able to follow doctor's recommendations?    Financial\_\_\_    Time\_\_\_    Location\_\_\_  
Other \_\_\_\_\_

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How committed are you to actively participating in moving yourself toward greater levels of happiness, peace, excitement, health, wellness and wholeness? (Circle)

Not at all    1    2    3    4    5    6    7    8    9    10    100% Committed

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

1 Orchard Blvd #07-01  
 Camden Medical Centre  
 Singapore 248649  
 Tel-(65)6836 0833  
 Fax-(65)6836 0830

500 Lorong 6 Toa Payoh  
 #04-34 HDB Hub  
 Singapore 310500  
 Tel-(65) 6258 6160  
 Fax - (65) 6258 5030

[www.spine.sg](http://www.spine.sg)

**\*\*\*\* If this is your first visit please only fill your health concerns and the Evaluation 1 column.**

## OUTCOME ASSESSMENT QUESTIONNAIRE

Name \_\_\_\_\_

Our goal is to give you the highest quality health care imaginable. In addition to the “objective” tests the doctor will evaluate, we would like to find out more about your “experience.” As we correct the subluxations or nerve interference and you make appropriate lifestyle changes we find that the majority of our practice members not only “feel better” but also have some “unexpected improvements” in their overall health, well being and quality of life!

**DATE:** \_\_\_\_\_

Health Concerns: Please rate your health concerns on a 0-10 scale; in which 10 is <b>BEST</b> and 0 is <b>WORST</b> imaginable	Evaluation 1	Evaluation 2	Evaluation 3	Evaluation 4
1.				
2.				
3.				
4.				
Any new health concerns since last evaluation: 10 = best, 0 = worst				
1.				
2.				
I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid				
I am able to notice tension and release it in my body. 10 is I can completely notice tension and release it, 0 is not at all				
My overall posture & ease in standing straight 10 = great, 0 = terrible				
I sleep deep and wake up feeling rested 10 = rested, 0 = tired				
I feel I have energy for all my daily activities 10 = a lot, 0 = none				
I feel emotions like anger, depression, unhappy, hopeless 10 = no anger , 0 = severe anger				
I feel emotions like joy, happiness, gratitude, hope 10 = a lot of joy, 0 = no joy				
I notice a deeper awareness of what my body wants from me in relation to (sleep, rest, exercise, movement, diet) since receiving adjustments 10 = yes, 0 = no				
I have less illness and recover faster. 10 = yes, 0 = no				
My self-perception is 10 = excellent, 0= terrible				
My spiritual connection 10 = excellent , 0= none NA= not applicable				
My diet is 10= excellent, 0 = terrible				
My exercise is 10 = excellent, 0 = none				
My strategies to deal with emotional stress 10 = excellent, 0 = terrible				
On the 1-100 scale, 50 being crisis, I believe I am now at:				
On the 1-100 scale, 50 being crisis, I would like to be at:				
My main goal is: 0 = still cannot do it, 10 = fully reached goal				
New main goal is (later in care): 0 = cannot do it, 10 = fully reached goal				