Align CHIROPRACTIC
Feel Better, Move Better, Be Better

No 1, Beech Rise Business Park, Beech Avenue
Norwich
Norfolk
NR8 6HW
UK

Welcome to our office

As a newcomer to Align Chiropractic we hope that you will soon be experiencing a new appreciation and understanding of the wonderful human body. Our care is designed to help you feel better, move better and be better by working together with you.

Surname: **Forename(s):**

Age: **DOB:**

Address:

Best phone number to contact you on:

Email:

Marital Status:

Who may we thank for referring you/ How did you find us?

Occupation:

Name of GP Practice:

Do you intend to reclaim your fees through health insurance?

Your Body is designed to be healthy. If it is not, there is always a cause or reason. Throughout life many events occur that may have an impact on your health and the following questions will help your Chiropractor assess this.
Please tick and complete where appropriate. All information will be handled in the strictest confidence.

Your General Health History:

Have you at any time suffered:

O Broken Bones. **Age & Details:**_____

O Motor Vehicle Accidents **Age & Details:** _____

O Surgery **Age & Details:** _____

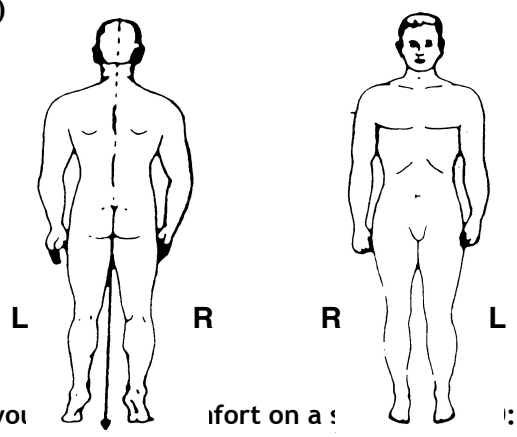
O Other Significant physical or emotional trauma, Illness or Hospitalisation
Details:_____

Do you take any medication or drugs (prescribed or otherwise*)?

*We can photocopy your prescription list if you prefer

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

Reason for your visit today? General wellbeing or are you currently suffering any pain or illness? (Please describe them & draw the location on the diagrams)



Please Indicate on the following scale how you would rate you **ıfort on a s** **ı:**

1 No Pain — 10 Extreme Pain

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

1 Poor — 10 Excellent

Number of hours quality sleep per night:	
How many pillows do you use?	
How old is your mattress?	

Your Goals from your visits: O Relief from Symptoms O Correction of Problems O Improved Health & Wellbeing

What aspects of your health currently concern you?

Do you or have any of your direct relatives suffered with :

O Headaches	O Change/loss of vision	O Diarrhoea	O Prostate problems
O Dizziness	O Hearing Change	O Irritable Bowel	O Urinary difficulty
O Ringing in ears	O Chest Pain	O Cystitis	O Pins & Needles
O Hayfever	O Shortness of Breath	O Numbness	O Urinary Tract Infection
O Palpitations	O Varicose Veins	O Asthma	O Arthritis/joint swelling
O Heart Attacks/Angina	O Fatigue / tiredness	O Allergies	O Eczema / skin disease
O Stroke / TIA	O Loss of balance	O Indigestion	O Rapid weight loss
O High Blood Pressure	O Incontinence	O Ear Infections	O Epilepsy/fits/seizures
O Low Blood Pressure	O Constipation	O Cancer	O Diabetes
O Loss of consciousness	O Jaw Clicking	O dental problems	

What is your sleeping posture? **O Side** **O Stomach** **O Back**

Women only (in blue text)

No & Age of children: _____

Reproductive issues can place a strain on your body's resources, Have you or do you have:
Period Pain / discomfort/ PMT/ Irregular Periods
Have you experienced any fertility problems (please give details if needed) _____

_____

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

Have you experienced any problems during pregnancy (please give details): _____
or during birth: _____

PRIVACY NOTICE:

- ALIGN CHIROPRACTIC WILL SEND YOU TEXT/EMAILS TO CONFIRM OR REMIND YOU OF YOUR UPCOMING APPOINTMENTS, WE ALSO SEND YOU A REMINDER AT 10AM THE DAY BEFORE YOUR APPOINTMENT UNLESS DIRECTED OTHERWISE.
- I HAVE BEEN SHOWN AND HAVE READ A COPY OF OUR PRIVACY POLICY (IF YES PLEASE TICK BOX) ☐
- I WOULD LIKE TO RECEIVE A BIRTHDAY CARD ONCE A YEAR WITH A DISCOUNT VOUCHER (IF YES PLEASE TICK BOX) ☐
- I AM HAPPY TO BE EMAILED A BIMONTHLY NEWSLETTER ABOUT NEWS AND PRODUCTS AT ALIGN CHIROPRACTIC ☐

CONSENT TO A CHIROPRACTIC EXAMINATION:

I UNDERSTAND THAT I WILL BE REQUIRED TO WEAR A GOWN FOR THIS PROCEDURE.
I CONFIRM THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED: _____ DATE: _____

I UNDERSTAND THAT ANY X-RAYS/OTHER DIAGNOSTIC TESTS UNDERTAKEN BY THE CLINIC REMAIN THE PROPERTY OF THE CLINIC AND WILL ONLY BE RELEASED TO OTHER PARTIES WITH MY PRIOR AGREEMENT. I UNDERSTAND AND GIVE CONSENT TO THE CHIROPRACTOR TO MAINTAIN MY RECORDS AS DETAILED ABOVE.
O PATIENT / O PARENT / O GUARDIAN (please select one)

SIGNED: _____ DATE: _____