



**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Post Code** \_\_\_\_\_

**E- Mail address** \_\_\_\_\_

**Phone (H)** \_\_\_\_\_ **(W)** \_\_\_\_\_ **(M)** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Occupation:** \_\_\_\_\_

**Number of Children and Ages** \_\_\_\_\_

**Who Were You Referred by?**  Friend,  Family,  Health Workshop,  Locality,  Advert,  Website,  Yellow Pages,  Dentist,  Maternal Child Health Nurse,  Other: \_\_\_\_\_

**Why Are You Here?** \_\_\_\_\_

How would you like things to be? \_\_\_\_\_

How does it affect you? \_\_\_\_\_

What activities aggravate this? \_\_\_\_\_

What activities improve this? \_\_\_\_\_

Is this condition becoming progressively worse?  Yes  No

Have you consulted any other health practitioner? \_\_\_\_\_

**Have You Ever Received Chiropractic Care?**  Yes  No

If you have had Chiropractic care before, please complete the following;

**Name of the Chiropractor** \_\_\_\_\_ **Located** \_\_\_\_\_

Do you have a current set of x-rays (within 6 months)?  Yes  No

**Are you a member of a health fund that covers Chiropractic Care ?**  Yes  No

**Is this a work cover case?**  Yes  No **Is this a Transport Accident Case?**  Yes  No

**Past History - Events that have happened in the past can affect your current health**

Please list any surgery you have had \_\_\_\_\_

What medication are you on? \_\_\_\_\_

How many motor vehicle accidents have you been involved in? \_\_\_\_\_

List ALL your traumas/accidents/falls since childhood. **(Very Important)**

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

**What position do you sleep in?**  Side  Stomach  Back

What are your favourite activities or hobbies? \_\_\_\_\_

How are your current problems affecting these activities? \_\_\_\_\_

**On a scale of 1 -10 ( 1 being the least and 10 the most)**

How committed are you to being at your maximum health potential? \_\_\_\_\_

How important is it for your family to be at their maximum health potential? \_\_\_\_\_

**Signature:** \_\_\_\_\_

# VERTEBRAL SUBLUXATION AND NERVE CHART

“The nerve system controls and coordinates all organs and structures of the body.” (Gray’s Anatomy, 29<sup>th</sup> ed., page 4). Misalignment of spinal vertebrae and discs may cause irritation to the nervous system, which could affect the structures, organs, and functions listed under “areas” and “possible symptoms” that are associated with malfunctions of the areas noted. **TICK PRESENT SYMPTOMS AND X PAST SYMPTOMS**



Spinal Nerves	Supplies this part of the body	Possible Symptoms
C1	Blood supply to the head, pituitary gland, scalp, face, brain, inner and middle ear.	<input type="checkbox"/> Insomnia <input type="checkbox"/> dizziness <input type="checkbox"/> nervousness <input type="checkbox"/> head colds <input type="checkbox"/> chronic tiredness <input type="checkbox"/> high blood pressure <input type="checkbox"/> headaches/migraines
C2	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	<input type="checkbox"/> Sinus troubles <input type="checkbox"/> allergies <input type="checkbox"/> fainting spells <input type="checkbox"/> pain around the eyes <input type="checkbox"/> earache <input type="checkbox"/> deafness <input type="checkbox"/> certain cases of blindness <input type="checkbox"/> crossed eyes
C3	Cheeks, outer ear, face bones, teeth, Trifacial nerve.	<input type="checkbox"/> Facial Neuralgia <input type="checkbox"/> acne <input type="checkbox"/> eczema
C4	Nose, lips, mouth, eustachian tube.	<input type="checkbox"/> Hay fever <input type="checkbox"/> runny nose <input type="checkbox"/> hearing loss <input type="checkbox"/> adenoids
C5	Vocal cords, neck glands, pharynx.	<input type="checkbox"/> Frequent sore throats <input type="checkbox"/> hoarseness
C6	Neck muscles, shoulders, tonsils.	<input type="checkbox"/> Stiff neck <input type="checkbox"/> pain in upper arm <input type="checkbox"/> tonsillitis <input type="checkbox"/> chronic cough <input type="checkbox"/> croup
C7	Thyroid gland, bursa in the shoulder, elbows.	<input type="checkbox"/> Bursitis <input type="checkbox"/> colds <input type="checkbox"/> thyroid conditions
T1	Trachea, oesophagus, inner arm to wrists and fingers	<input type="checkbox"/> Asthma <input type="checkbox"/> cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> pain down length of arm
T2	Heart including its valves, coronary arteries	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> functional heart conditions
T3	Lungs, bronchial tubes, pleura, chest, breast.	<input type="checkbox"/> Bronchitis <input type="checkbox"/> pneumonia <input type="checkbox"/> congestion <input type="checkbox"/> difficulty taking a deep breath
T4	Gall bladder, common duct	<input type="checkbox"/> Fatty stools <input type="checkbox"/> jaundice <input type="checkbox"/> shingles
T5	Liver, solar plexus, circulation (general)	<input type="checkbox"/> Liver conditions <input type="checkbox"/> fevers <input type="checkbox"/> arthritis <input type="checkbox"/> poor circulation <input type="checkbox"/> blood pressure problems
T6	Stomach	<input type="checkbox"/> Stomach troubles <input type="checkbox"/> indigestion <input type="checkbox"/> heartburn
T7	Pancreas, duodenum	<input type="checkbox"/> Ulcers <input type="checkbox"/> gastritis <input type="checkbox"/> diabetes
T8	Spleen	<input type="checkbox"/> Lowered resistance to disease
T9	Adrenal and suprarenal glands	<input type="checkbox"/> Fatigue <input type="checkbox"/> allergies <input type="checkbox"/> hives
T10	Kidneys	<input type="checkbox"/> Kidney troubles <input type="checkbox"/> chronic tiredness
T11	Ureters	<input type="checkbox"/> Skin conditions such as <input type="checkbox"/> eczema (dry skin), <input type="checkbox"/> acne <input type="checkbox"/> pimples
T12	Small intestines, lymph circulation	<input type="checkbox"/> Gas pains <input type="checkbox"/> certain types of sterility <input type="checkbox"/> rheumatism
L1	Large intestine, upper thigh	<input type="checkbox"/> Constipation <input type="checkbox"/> colitis <input type="checkbox"/> diarrhoea <input type="checkbox"/> irritable bowels <input type="checkbox"/> hernias <input type="checkbox"/> groin pain
L2	Abdomen, appendix	<input type="checkbox"/> Cramps <input type="checkbox"/> minor varicose veins
L3	Bladder, uterus, sex organs, knees	<input type="checkbox"/> bladder troubles <input type="checkbox"/> menstrual troubles such as painful or irregular periods <input type="checkbox"/> miscarriages <input type="checkbox"/> bedwetting <input type="checkbox"/> impotence <input type="checkbox"/> many knee pains
L4	Prostate gland, low back muscles, sciatic nerve	<input type="checkbox"/> Sciatica <input type="checkbox"/> lumbago <input type="checkbox"/> backaches <input type="checkbox"/> Difficult or too frequent urination
L5	Lower legs, ankles, feet	<input type="checkbox"/> Poor circulation in the legs <input type="checkbox"/> cold feet <input type="checkbox"/> leg weakness <input type="checkbox"/> foot drop
Sacrum	Buttocks, hips	<input type="checkbox"/> Sacroiliac conditions <input type="checkbox"/> pain in buttocks
Coccyx	Rectum, anus	<input type="checkbox"/> Haemorrhoids (piles) <input type="checkbox"/> itching <input type="checkbox"/> pain at the end of spine on sitting