LivingRoom
Falmouth Marina
North Parade
Falmouth
TR11 2TD
info@myliving-room.com

Welcome to your LivingRoom - Helping you to help yourself.

Please print and complete this form and bring it with you to your first visit.

FIRST VISIT - INFORMATION ABOUT YOU

Full Name: Date of Birth:

Address:

Post Code:

Mobile: Home: Work:

Occupation:

Marital Status: S M D W Partners Name:

Children's Names and Ages:

Who told you about LivingRoom?

Have you had Chiropractic Care before? Y / N

Who, Where and When?

Do you have X-Ray or MRI Scan Reports? Y / N (Please bring them with you on your first visit)

Do you have Health Insurance that covers Chiropractic Care? Y / N Provider:

Provider Member No.: Authorisation Code:

Name of GP: Practice Address:

In your own words please tell us how we can best help you?

What do you think might be the cause of this problem?

You are constantly trying to heal yourself. The following questions will help us to determine any factors that may have contributed to your health. Please complete where appropriate with a tick.

YOUR BIRTH

This can be a wonderful and/or traumatic event for both Mother and Baby and can result in some irritation to the spine. Was your birth:

0 Forceps/Suction 0 C-Section 0 Induced 0 Breech 0 Drug Assisted 0 Unsure

YOUR CHILDHOOD

This can often be a time where problems originate that can effect us later in life. As a child did you suffer from any of the following:

0 Colic 0 Allergies 0 Ear Infections 0 Asthma 0 ADHD 0 Tonsillitis
0 Dyslexia 0 Bed Wetting 0 Behavioural Problems 0 Other:

Did you:

0 Get Breast Fed 0 Sleep Badly 0 Bang your head a lot against your cot
0 Have any major accidents (inc car accidents) 0 Have Surgery 0 Require Medication
0 Use a baby walker/bouncer 0 Have any sports injuries 0 Sleep on your stomach

Age of trauma or surgery :

Were you:

0 Vaccinated 0 Not Vaccinated 0 Unsure

GENERAL HEALTH

Have you had any of the following (please inc. dates/age):

0 Significant Sprains - Details:

0 Fractures - Details:

0 Significant Injuries - Details:

0 Significant falls - Details:

0 Loss of Consciousness - Details:

0 Surgery - Details:

0 Road Traffic Accidents - Details:

0 Hospitalisations - Details:

0 Long Term Medications - Details:

Do you currently take any Medications? Details:

Do you or have you suffered with any of the following:

0 Headaches 0 Migraines 0 Visual Disturbance 0 Ringing in the ears 0 Loss of Hearing
0 Loss of balance 0 Slurred Speech 0 Chest Pain 0 Palpitations
0 Panic Attacks 0 Depression 0 Shortness of Breath 0 Memory Loss
0 Heart Attacks 0 Angina 0 Stroke/Mini Stroke 0 Epilepsy/fits
0 High/Low Blood Pressure 0 Fatigue/Tiredness 0 Loss of Bowel/Bladder Function
0 Constipation 0 Diarrhoea 0 Cystitis 0 Allergies
0 Asthma 0 Eczema 0 Psoriasis 0 Indigestion
0 Cancer 0 Arthritis 0 Auto-Immune Conditions
0 Diabetes 0 Numbness 0 Pins and Needles 0 Dental Problems
0 Work Stress 0 Emotional Stress 0 Physical Stress 0 Chemical Stress
0 Anxiety 0 IBS/Bloating 0 Rapid Weight Loss

Do you regularly (more than once a week)?:

0 Exercise 0 Meditate 0 Play Contact Sport 0 Relax
0 Sit for Long periods 0 Bend and Lift Repeatedly 0 Lift Heavy Things
0 Use a Computer 0 Use a Mobile Device 0 Sauna
0 Play an Instrument 0 Drive/Travel for Long Periods 0 Operate Machinery

How would you rate your Posture on a scale of 1-10 (Poor-Excellent)?

At Work: At Home:

NUTRITION AND ENVIRONMENT

Do you Smoke? Y/N How many a day? For how many years?

Do you drink Alcohol? Y/N How many glasses per week?

Do you drink fruit juice? Y/N How many glasses per week?

How many glasses of water do you drink per day?

How many fresh vegetables do you eat per day?

How much fresh fruit do you eat per day?

What percentage of the food you consume is Organic?

What supplements/vitamins do you regularly consume?

Out of 10 how would you rate your sweet tooth (10 being sweetest)?

Please describe yesterdays food and drink consumption:

Breakfast:

Lunch:

Dinner:

Snacks:

Name three foods you would never want to give up? 1)

2)

3)

SLEEP

How many hours of sleep do you get a night?

Do you have any ambient noise or light in your bedroom?

Do you have a TV or Mobile Device in your bedroom?

Rate the quality of your sleep out of 1-10 (Poor-Exellent)?

HEALTH, VITALITY AND PERFORMANCE

Please tick the 'top 3' health goals most important to you:

0 I want to be the best I can possibly be
0 I want to see how good I can feel
0 I want to perform better
0 I want to feel confident, fit and well
0 I want more energy and enthusiasm
0 I want to get rid of my pain
0 I want to feel in better control of my mind and body
0 I want to feel less stressed
0 I want to sleep better
0 I want to improve my athletic performance
0 I want to prevent further injuries
0 I want to improve my nutrition and digestion
0 I want to feel less anxious
0 I want to create and maintain a state of wellness
0 I want to remove any irritation to my nervous system communication
0 I want my spine and nervous system to work as well as possible
0 I want to learn how to be stronger and more resilient
0 I want to feel like me again

What activities would you ideally like to take up or return to?

Consent

I consent to a Chiropractic analysis. I understand that I may be required to wear a gown for this procedure. If you should prefer please arrange for a chaperone to accompany you. I consent to photographs being taken of me for the purposes of diagnosis and that these images are retained securely. I confirm that the information provided in this form is to the best of my knowledge true and correct.

Name:

Signed:

Date: