TOTALHEALTH
CHIROPRACTIC • SINGAPORE

PERSONAL DETAILS

Name (According to IC/Passport) ……

Preferred name to be addressed: …… Gender: ……

Address: ……

Birth Date: …… Age …… Nationality: ……

☐ Singaporean ☐ PR ☐ EP/Work Permit ☐ Tourist

Mobile #: …… NRIC: First three digits and last alphabet only: ……

Email Address: ……

Occupation: …… Employer: ……

Do you have children? Yes / No

Who may we thank for your referral? ……

Have you seen a Chiropractor before? Yes / No If yes, where ……

Reason for today's visit? ……

HEALTH QUESTIONNAIRE

Are you a smoker Yes / No Do you wear insoles? Yes / No

Do you exercise regularly? Yes / No / Moderate If yes, type of exercise? ……

Are you taking any medication at all? Yes / No

If yes, please list and for what condition? ……

……

Previous accidents or injuries? (e.g. whiplash, car, bike, sporting) ……

……

Do you feel your current symptom(s) is related to a previous accident/trauma Yes / No

Any major illness/operations? ……..……

……

How many hours a day do you spend a) Sitting [ ] b) Computer [ ]

For females: Are you pregnant? Yes / No / Unsure If yes, weeks/months: ……..……

Any fertility concerns? ……..……..……..

Please circle if you experience any of the following symptoms:

Neck Pain	Headaches	TMJ (jaw problem)	Hearing problems
Thyroid condition	High blood pressure	Numbness/tingling in arms/hands	Pain in shoulders, arms or hands
Recurrent colds/flu	Dizziness	Allergies/hay fever	Weakness in grip
Visual disturbances	Low energy/fatigue	Mid back or shoulder blade pain	Asthma/wheezing
Pain w. deep breath/expiration	Nausea	Indigestion, heartburn or reflux	Recurrent lung infections or bronchitis
Shortness of breath	Heart disease/angina	Pain in ribs/chest	Hypoglycemia
Family history of diabetes	Heart palpitations	Ulcers/gastritis	Low back pain
Numbness/tingling in legs/feet	Frequent/difficulty urinating	Muscle cramps in legs/feet	Injury in hip, knee or ankle
Pain in hips/legs/feet	Recurrent bladder infections	Menstrual irregularities/cramps	Sciatica
Constipation or diarrhea			

Please describe any spine/health concerns below:

1. …….. For how long? ……..

2. …….. For how long? ……

3. …….. For how long? ……

Does this cause you to be? (Please circle)

Moody Irritable Have interrupted sleep Restricted in daily activities

How does this affect your work? (Please circle)

Decision making Poor attitude Decreased productivity Exhausted at end of day

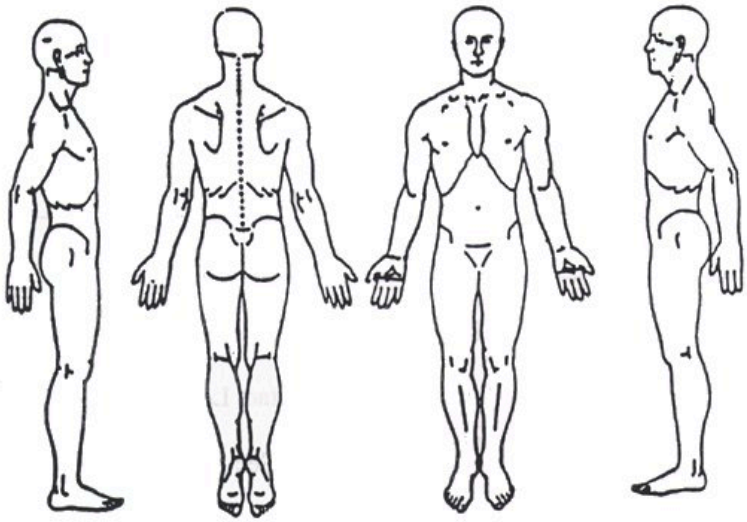
How does this limit your life? What things can you not do? (Please circle)

Lose patience with your family Restricted in household duties Exercise/sport hindered

Other ……

How motivated are you to tackle this concern? Not really / Somewhat / Very / 100%

Please indicate your area(s) of pain or discomfort:



Right Left Right Right Left Left

On a scale of 1 – 10 (10 being the highest) how important is your health to you?

0 1 2 3 4 5 6 7 8 9 10

Not important Fairly important Most important

If Chiropractic care is right for you, would you prefer our clinic in: (please circle):
Capital Tower Amoy Street Tampines Toa Payoh Clementi

Signed: …… Date: ……