

Swedish QINOpactic and Rehab Clinic - Health Declaration

Name: _____ D.O.B: _____
 Address: _____
 Postcode: _____ Mobile: _____
 Phone: _____ E-mail: _____
 Occupation: _____ Children? Age/ages: _____
 General Health: _____ Height: _____ Weight: _____
 Sport/Activities/Hobbies _____ Times p/w: _____

Reason for visit: _____
(Describe your issue, pain and its nature)

Current/ Previous treatment: _____
(i.e. GP, Consultant, Physio, Chiro, Osteo)

GP Name / Surgery Address: _____

Source, referral? _____
(i.e. recommendation, internet, other)

Accidents: _____
(i.e. Unconsciousness, Head/ Neck/ Spine Injuries, Whiplash, Breaks or Sprains)

Related/ Hereditary Health Issues in the family: _____
(i.e. Rheumatism, Diabetes, Heart issues)

Neurological issues: _____
(i.e. Neurofunctional disorders, (like ADHD, ADD, Autism, Asperger), Dementia, Alzheimers)

Current medication and for what condition: _____

Tick one of the options Yes / No. If yes, please tell us.

	Yes	No	If yes, Comment behind each question/ situation/ type
Allergies/intolareneces	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	if yes; how many p/d _____ How many years: _____
Drinking habits	<input type="checkbox"/>	<input type="checkbox"/>	if yes; Quantity and regularity: _____
Eating and Hydration habits	<input type="checkbox"/>	<input type="checkbox"/>	Food type/ Water Ltr p/d: _____
Earlier tumors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Earlier heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High/ low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	If yes: What is your blood pressure: _____
Previous fractures/ breaks	<input type="checkbox"/>	<input type="checkbox"/>	_____ Complications Y N
Previous surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____ Complications Y N
Stomach/intestinal issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current injuries or illnesses:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous injuries or illnesses:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep problems/issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migranes	<input type="checkbox"/>	<input type="checkbox"/>	Where and how often _____
Previous cortisone injections	<input type="checkbox"/>	<input type="checkbox"/>	Location and number _____
Fainting/Vertigo/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain when sneezing/coughing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy due date? _____
I feel perfectly healthy	<input type="checkbox"/>	<input type="checkbox"/>	_____

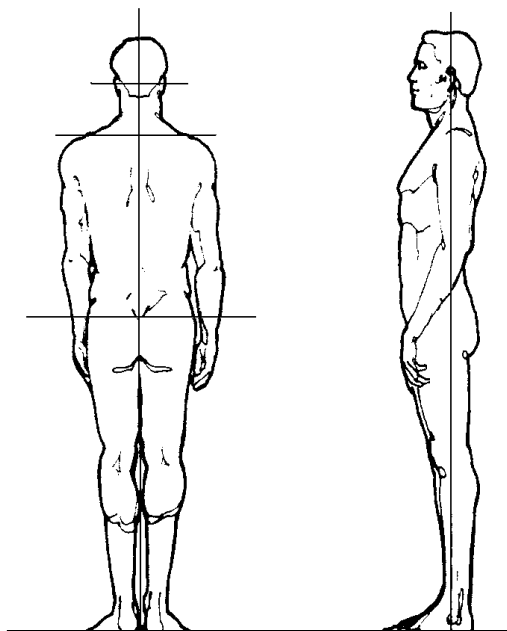
Stress/anxiety/Emotional conditions: _____

Do you feel that you're stuck with negative thought patterns? _____

Other issues/ conditions not specified above: _____

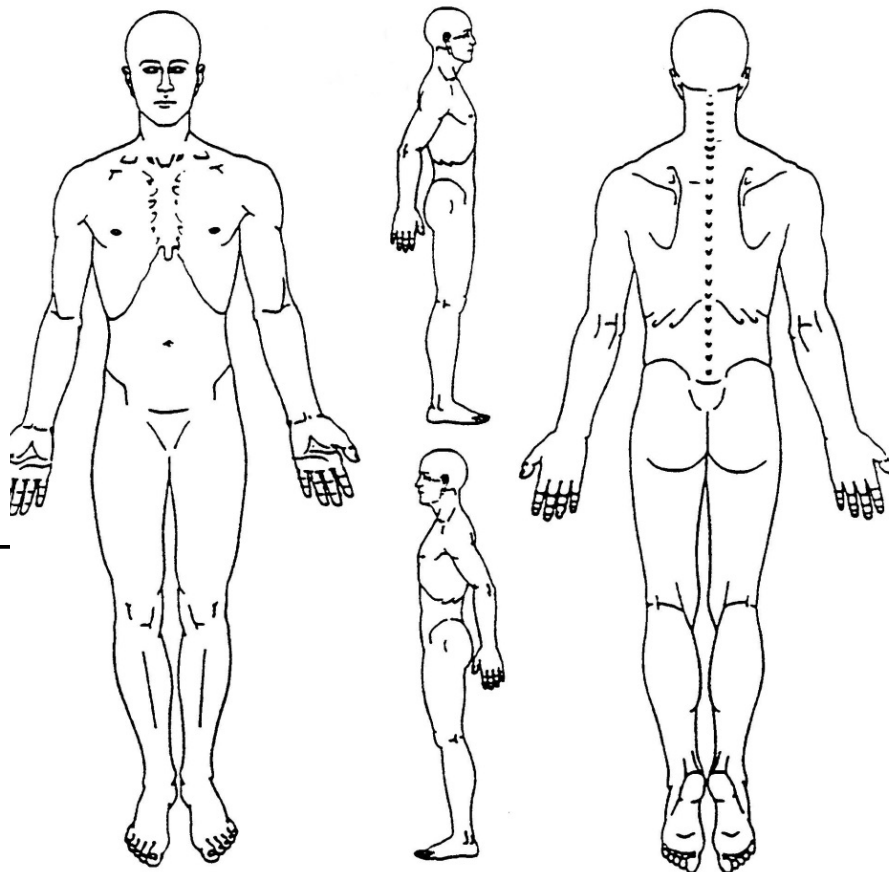
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Posture Chart



Symptom Chart

Indicate (with a pen on the symptom chart) where you're currently experiencing pain/problems:



Your Expectation of the Treatment session:

Client / Patient

I hereby consent to treatment, which will be discussed with my practitioner.

I have stated all conditions that I am aware of and this information is true and accurate. I will inform my practitioner of any changes in my status/significant changes between treatments, such as medication/ side effects/ pregnancy, etc.

I agree to the payment terms and note that I am required to notify SweQino no later than 19,00 the evening before the appointment, otherwise the full fee will be charged.

I am aware that my practitioner assesses and addresses soft tissue, musculoskeletal issues and energy imbalances in the body and does NOT diagnose diseases/conditions.

This treatment is exercising soft tissue therapies and QINOpactic care, not Chiropractic care.

I hereby consent to examination, treatment, photography for feedback/ postural assessment and have been informed by the practitioner about said treatment(s). I also confirm that by signing this Client Record that I agree to the cancellation terms for appointments and my personal information will be treated and held private and confidentially as per the Privacy Policy under the General Data Protection Regulation 2018 have been given and read.

Signature: _____

Date: _____

I, SweQINO, and the practitioners within, declare that we do not treat diseases or diagnose conditions. We further verify that we do NOT manipulate the body's chemistry, as in western medicine. We are board certified and a member of a professional association and have all the insurance required by Spanish and European governing bodies. We work to balance the body, on soft tissue and energetic level (i.e. NOT chemical level). With the client's / patient's signature, they have agreed that we can treat them for the reason/ imbalance they are presenting with in our clinic.