



Palmyra 61 carrington st p 9319 2552 f 9319 2211
Kalamunda 7 stirk st p 9293 2999 f 9293 2023
Yokine 3/21 wanneroo rd p 9201 2330 f 9201 0559
Kelmescott 2915 albany hwy p 9293 2999 f 9293 2555

Date: ____/____/____

File number _____ (Office use only)

The purpose of our clinic is to relieve pain, restore health and improve the quality of life in each patient we accept for care. For us to properly understand your health problem we need a complete history of your present symptoms (Should you have any.) We also need information about your general overall health. This in-depth knowledge will help us determine the type of care needed and give some indication as to what can be anticipated in your case. Please answer every question completely and to the best of your ability. By doing so we will not have to ask you a lot of questions about health problems that do not pertain to your case. If, after consultation and/or examination, we do not sincerely believe you will benefit from Chiropractic care, then we will find the right professional for you. Thank you for your cooperation in completing this form.

Personal Information

Title: (Please circle) Mr / Mrs/ Ms/ Miss/ Mst/ Dr.

Name _____

Address _____ City _____ Post Code _____

Telephone (Res) _____ (Bus) _____ (Mobile) _____

Email _____ Date of Birth _____ Age _____

Occupation _____ Employer _____ Health Fund _____

Marital Status _____ Spouse Name _____

Children's names and ages _____

Which one of our patients referred you? _____

Is this injury work related? Yes No Is this a Motor Vehicle Case? Yes No

Is this a general check up? Yes No

Previous and Current Health

Major complaint _____

Other Complaints _____

How long have you had this condition? _____

Is it getting; Worse? Constant? Comes/Goes? Getting Better?

What makes the symptoms better? _____

Have you consulted anyone about your problem Yes No Who: _____

What was the diagnosis? _____

What was the treatment given? _____

Have you ever had these symptoms before? Yes No

What caused them then? _____

Have you ever had a serious health problem? Yes No

If Yes please describe _____

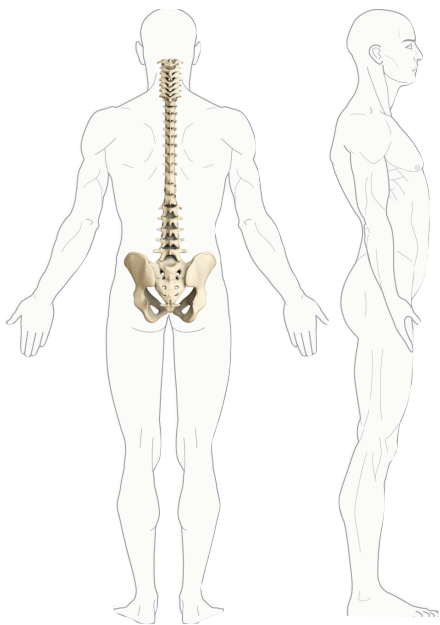
Have you ever had any surgery? Yes No

Please list _____

Have you ever had any accidents (IE MVAs or falls) Yes No

Please specify _____

Please mark your areas of pain on the figures below



Have you ever seen a chiropractor before? Yes No

Who? _____

Where? _____

When was your last visit? _____

How often were you attending? _____

How did you find the results? (Please circle)

excellent good fair poor no change felt worse

Were X-rays taken? Yes No

When? _____

Have you been taking drugs or medication? (Please circle)

Anti-inflammatory Muscle Relaxants Pain-Killers

Anti-Depressants Birth Control Pill

Other- Please list all medications _____

Pain scale (least Pain) 1 2 3 4 5 6 7 8 9 10 (Worse)

Are you taking any supplements (vitamins/minerals) Yes No

If Yes please list _____

How long has it been since you felt really well? _____

Please mark the following symptoms/conditions: (O)- occasionally (F)- frequently(C)- constantly (N)- never

___ Convulsion/Epilepsy

___ Loss of Balance

Females Only

___ Fatigue

___ Dizziness

___ Painful or tender breasts

___ Nervousness

___ Sudden Loss of Weight

___ Period Pain

___ Low/High Blood Pressure

___ Depression

___ Excessive Menstrual Flow

___ Diarrhea/ Loose bowel

___ Sleeping Problems

___ Bleeding between periods

___ Shortness of breath/ Asthma

___ Bloatingness

___ Difficulty falling pregnant

___ Joint stiffness

___ Headaches

___ Menopausal Problems

___ Indigestion

___ Bursitis

___ Endometriosis

___ Nausea

___ Low Back Pain

___ Infertility

___ Sciatica

___ Painful tail bone/ Coccyx

Are you pregnant? Yes No

___ Heel pain

___ Neck pain or stiffness

___ Sweat Excessively/ Dry Skin

___ Kidney Infection

___ Restless Legs

___ Recurring Infections

___ Cramping

___ Constipation

___ Sexual Difficulties

___ Urinary Problems

___ Loss of Concentration

___ Bladder Weakness

Have you ever; Been knocked unconscious? Yes No

Been treated for a spine or nerve disorder? Yes No

Had a fractured/broken bone? Yes No

Been Hospitalised? Yes No

Used a cane or other support? Yes No

Family History

Is there a family history of the following conditions in your family? (Please circle)

Heart Disease

Arthritis

Stroke

Cancer

Diabetes

Back problems

Allergies

Other; _____

I, the undersigned, understand that all fees are payable at the time of consultation, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain re-embursement from insuring companies. Legal opinion is that X-rays remain the property of the clinic, however these will be forwarded to suitably qualified practitioners upon request.

This form was filled out by _____ on the request of _____

Signature: _____