

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 \_\_\_\_\_

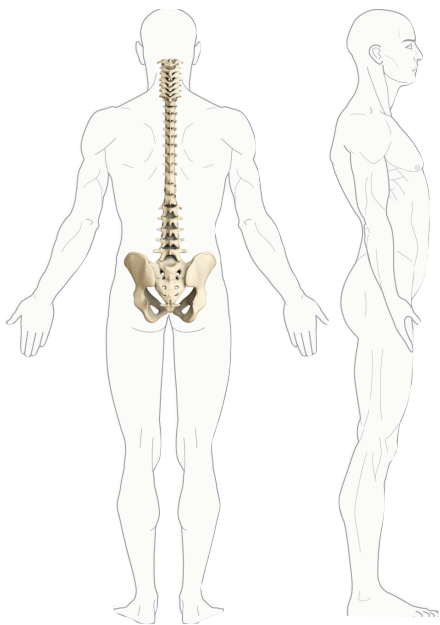
Have you ever had any surgery?      Yes      No

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