

Confidential Patient Information

YOUR CAREFUL ATTENTION to the questions below will help us to ensure appropriate care is provided. Please include **ALL** your medical information as Chiropractic works by addressing the nervous system therefore **EVERY ASPECT OF YOUR PAST AND PRESENT HEALTH STATUS IS RELEVANT.**

Surname: Given name: Title:

Preferred Name: Marital Status: Marr. Sgl. Wid. Div. Sep. Defacto

Address:

Suburb/Town: Postcode:

Home Ph: Business Ph: Mobile Ph:

Email Address:

Date of Birth: Occupation:

Children: (1) (3)

(2) (4)

Referred by: Family/Friend - Name: Family Doctor:

Yellow pages Newspaper Clinic Sign Internet

Are you a Pensioner/Health Care Card Holder? Yes/No Number:

Have you been to a Registered Chiropractor within the last 12 months? Yes/No

If yes: Who? When?

What is (are) the MAIN REASON(s) of your visit to this centre today?

(1)

(2)

(3)

When did this start?

What caused it?

Is your condition/pain getting progressively worse? Yes / No

What aggravates your problem?

What relieves your problem?

Rate the severity of your pain by marking an X on the following scale:

0.....1 2 3 4 5 6 7 8 9.....10
No Pain (please circle) Extreme Pain

How is this condition affecting your Lifestyle?

Rate your general health out of 10:/10 (10 equals Healthy)

Are any of the following involved? **WorkCover:** **TAC Claim:** **DVA:**
If so, please speak to Lynda or Georgie Yes / No Yes / No Yes / No
(please circle)

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Please indicate if you have **EVER** had, **NOW** or in the **PAST**, **ANY** problems in the following areas:

- | | | |
|---|--|---|
| <input type="checkbox"/> Eyes/Vision
<input type="checkbox"/> See spots/Lights/halos
<input type="checkbox"/> Ears
<input type="checkbox"/> Nose
<input type="checkbox"/> Neck
<input type="checkbox"/> Throat
<input type="checkbox"/> Shoulders
<input type="checkbox"/> Upper Arm
<input type="checkbox"/> Elbows
<input type="checkbox"/> Forearms
<input type="checkbox"/> Hands
<input type="checkbox"/> Wrists
<input type="checkbox"/> Lower Back
<input type="checkbox"/> Upper Back
<input type="checkbox"/> Stomach or Abdomen
<input type="checkbox"/> Pelvis
<input type="checkbox"/> Hips
<input type="checkbox"/> Groin
<input type="checkbox"/> Thighs
<input type="checkbox"/> Calves
<input type="checkbox"/> Knees
<input type="checkbox"/> Lower Legs
<input type="checkbox"/> Ankles | <input type="checkbox"/> Feet
<input type="checkbox"/> Chest
<input type="checkbox"/> Lungs
<input type="checkbox"/> Bladder Control
<input type="checkbox"/> Bladder Infections
<input type="checkbox"/> Bowels
<input type="checkbox"/> Constipation/Diarrhoea
<input type="checkbox"/> Jaw
<input type="checkbox"/> Reproductive organs
<input type="checkbox"/> Nervous System
<input type="checkbox"/> Skin
<input type="checkbox"/> Headaches
<input type="checkbox"/> Migraine
<input type="checkbox"/> Allergies
<input type="checkbox"/> Hay fever
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pancreas
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Heart
<input type="checkbox"/> Circulation | <input type="checkbox"/> Kidneys
<input type="checkbox"/> Blood Pressure Hi/Low
<input type="checkbox"/> Growing Pains
<input type="checkbox"/> Sleep
<input type="checkbox"/> Balance
<input type="checkbox"/> Co-ordination
<input type="checkbox"/> Attention Span
<input type="checkbox"/> Concentration
<input type="checkbox"/> Speech
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Forgetful
<input type="checkbox"/> Moody
<input type="checkbox"/> Hearing
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Taste
<input type="checkbox"/> Pins & Needles
<input type="checkbox"/> Cramps
<input type="checkbox"/> Pain Coughing/Sneezing
<input type="checkbox"/> Pain Waking at Night
<input type="checkbox"/> Fainting/Blackouts
<input type="checkbox"/> Unexplained Bleeding
<input type="checkbox"/> Unconsciousness |
|---|--|---|

Have you ever had **ANY** surgery **Yes/No** – (please circle)

List (1)(3)
 (2) (4)

Do you take **ANY** medication? **Yes/No** – (Include Prescription, non-script & dietary supplements)

List (1)(3)
 (2) (4)

CONSENT TO CHIROPRACTIC CARE

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. We will recommend that you seek the services of a health care provider who specialises in that area.

OUR PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our principle method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

Signed _____ Date ____/____/____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____, being the parent/legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

X-ray evaluation is an important tool for determining appropriate care. However, x-rays are unsafe to an unborn child. Please advise if you think you could be pregnant. Initial here: _____