Confidential Patient Information

YOUR CAREFUL ATTENTION to the questions below will help ensure appropriate care is provided. Please include **ALL** your medical information - **EVERY ASPECT OF YOUR PAST AND PRESENT HEALTH STATUS IS RELEVANT.**

Surname: ……..…..... Given name: ……..…….. Title: .....

Preferred Name: ……...… Occupation: ……..…… Date of Birth: …….

Full Address: ……..……..…….....

Home Ph: ……..…… Business Ph: ……..……..……..…… Mobile Ph: ……..……...

Next of Kin: ……..… Relationship to you: ……...…… Contact: ……..……

Children's Names……..……..…….

Email Address: ……..…… Would you like to receive email updates? **Yes/No**

Referred by: ☐ Family or Friend - Name: …… ☐ Clinic Sign ☐ Newspaper
☐ Family Doctor: ……..... ☐ Internet ☐ Yellow pages

Private Health Insurance **Yes / No** Fund Name ..... 2 digit ID Number ☐☐

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

Is this a **WorkCover**, **TAC or Veterans Affairs** Claim? **Yes/No**
If yes, please speak to our Chiropractic Assistant now, before your appointment.

Have you had Chiropractic care before? **Yes/No** With Whom? ..... Last Visit: ……..

Your Health Profile

For Postural Assessment, please tell us the following: Height ……. Weight ……

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

...……...

When did this start? ……..……..……

What caused it? ……..……...

Is your condition/pain getting progressively worse? **Yes / No** (please circle)

What aggravates your problem? ...……..……..…….

What relieves your problem? .....

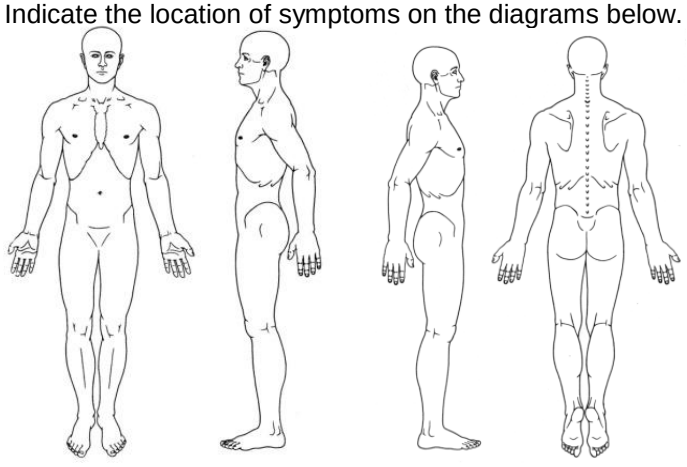
Have you experienced this condition before? **Yes / No** (please circle)

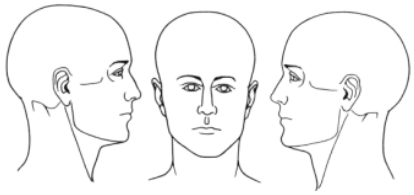
How many times: …… When was the last time? ……..…

Do you ***HAVE***, or ***WAS*** there ***ANY*** of the following prior to, or during the onset? (Please circle)

	Illness/Infection	Trauma	Night Sweats	Night Pain
	Nausea	Unsteady Walking	Dizziness	
Changes to:	Weight	Appetite	Vision	
	Head Pain	Bladder/Bowel Control		

Indicate the location of symptoms on the diagrams below.





Use these symbols to indicate in coloured pen:

Pain = x x x x Tingling = //////////

Numbness = oooo Other (please specify)

Rate the **severity of your pain** (if any) by marking an **X** on the following scale:

No Pain  Excruciating Pain

Does your complaint interfere with: ☐ **Work** ☐ **Sleep** ☐ **Hobbies** ☐ **Daily Routine** ☐ **Sport**

List if you have ***EVER*** had ***ANY*** Surgical Procedures?

Year: ..... Event: ..... Year: ..... Event: .....

Year: ..... Event: ..... Year: ..... Event: .....

Year: ..... Event: ..... Year: ..... Event: .....

List if you have ***EVER*** had ***ANY*** Fractured or Broken Bones**,** Vehicle or Sporting Accidents or Injuries?

Year: ..... Event: ..... Year: ..... Event: .....

Year: ..... Event: ..... Year: ..... Event: .....

Year: ..... Event: ..... Year: ..... Event: .....

List ***ANY*** medication or Supplements you take? (Include Prescription, non-script & dietary supplements)

List: .....

.....

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

Now	Past		Now	Past		Now	Past	
☐	☐	Eyes / Vision (Blurring etc)	☐	☐	Bladder Control / Infections	☐	☐	Growing Pains
☐	☐	See spots / lights / halos	☐	☐	Bowels	☐	☐	Balance / Co-ordination
☐	☐	Ears / Hearing / Ringing in ears	☐	☐	Constipation / Diarrhoea	☐	☐	Attention / Concentration
☐	☐	Nose / Jaw / Throat	☐	☐	Blood Pressure High/Low	☐	☐	Speech / Taste
☐	☐	Neck	☐	☐	Reproductive organs	☐	☐	Nausea / Vomiting
☐	☐	Shoulders /Upper Arm	☐	☐	Nervous System	☐	☐	Forgetful
☐	☐	Elbows / Forearms	☐	☐	Headaches / Migraine	☐	☐	Mood Changes
☐	☐	Wrists / Hands	☐	☐	Allergies / Hay fever	☐	☐	Fatigue / Exhaustion
☐	☐	Upper Back	☐	☐	Dizziness	☐	☐	Anxiety / Depression
☐	☐	Lower Back	☐	☐	Diabetes / Pancreas	☐	☐	Cramps
☐	☐	Pelvis / Hips / Coccyx	☐	☐	Thyroid	☐	☐	Jumpy Legs at Night
☐	☐	Groin / Thighs	☐	☐	Indigestion / Reflux	☐	☐	Motion Sickness
☐	☐	Calves / Lower Legs	☐	☐	Heart / Circulation	☐	☐	Unexplained Bleeding
☐	☐	Knees / Ankles / Feet	☐	☐	Kidneys	☐	☐	Loss of Appetite
☐	☐	Chest / Lungs / Asthma	☐	☐	Inflammatory Arthritis	☐	☐	Weight Loss / Gain
☐	☐	Low Energy	☐	☐	Knocked Unconsciousness	☐	☐	Fainting / Blackouts

Family History: Have any family members suffered from:

Heart Disease **Yes / No**, who? ..... Cancer **Yes / No**, who? .....

Stroke **Yes / No**, who? ..... Inflammatory Arthritis **Yes / No**, who? .....

Are there any other significant health concerns? **Yes / No** .....

GP's Name.....Address.....

CONSENT TO CONSULTATION & EXAMINATION

Please Print Patient name: ..... **Date**: .....

Patient's Signature (if 18yrs or older): .....

Parent's Signature (if patient is under 18): .....