Confidential Patient Information

Full Name: _____ Date: / /

Address: _____

Mobile number: _____ Email: _____

Occupation and Employer:_____

Date of Birth: / / Age:_____ Partner/Guardian name: _____

Marital Status: _____ No. of Children/Names:_____

Pregnant?: ☐ Yes Complications: _____

Who may we thank for referring you? _____

Addressing What Brought You Into Our Office:

If you have no symptoms/ concerns and here for proactive Chiropractic care, please skip to the "General Health History"

Any Health Concerns

Please list your health concerns according to severity	Rate of severity 1= mild 10= worst imaginable	When did this episode start?	Have you had this condition before? When?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Is your pain dull / sharp ? Does it radiate anywhere? If so, where? _____

What have you done for this condition? Has this helped?_____

Family history of this or similar symptoms? ☐ Y ☐ N If yes, please specify,_____

Which activities aggravate your condition?_____

Other health providers you have seen for this condition:_____

Doctor's details:

Name:_____ Suburb:_____

When did you see them? _____ What was wrong? _____

What did they do? _____ Did it help?☐ Y☐ N

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (ie. eat better, less alcohol or drugs, meditate or breathe more, less destructive sports/activities etc) If so, what?

Is this condition interfering with any of the following:

☐ Work ☐ Sleep ☐ Daily routine ☐ Sport/Exercise ☐ Other

What lesson(s) have you taken from your healing process to date? _____

General Health History

Have you had any surgery? (Please include all surgeries)

1.Type	When:	Where:
2.Type	When:	Where:
3.Type	When:	Where:

Current Medicines and Supplements:

Please list any medications / drugs you have taken in the past 6 months and why (prescription and non-prescription):

_____

Have you had any accidents/injuries? (car/bike/work/sport, especially related to you present condition)

1.Type	When:	Hospitalised: ☐ Y ☐ N
2.Type	When:	Hospitalised: ☐ Y ☐ N

Have you ever had x-rays taken? ☐ Y ☐ N If yes please indicate:

Area of body: _____ When: _____

Health History: Please mark the following condition you may have had or have now (- have had + have now)

☐ Allergies	☐ Anaemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma	☐ Bowel Problems
☐ Back Pain	☐ Cancer	☐ Cold sores	☐ Constipation	☐ Convulsions	☐ Cramps
☐ Diabetes	☐ Diarrhoea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gallbladder
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ PMS	☐ Gas/Bloating
☐ Irr Periods	☐ Low blood sugar	☐ Frequent colds	☐ Stress/Anxiety	☐ Ulcers	☐ Migraines
☐ Prostate	☐ Dysmenorrhea	☐ Blood Pressure	☐ Depression	☐ Insomnia	☐ Neuritis
☐ Miscarriage	☐ Multiple Sclerosis	☐ Indigest/Heartburn	☐ Neck Pain	☐ Flatulence	☐ Period pain
☐ Pleurisy	☐ Pneumonia	☐ Frequent urination	☐ Bladder Infection	☐ Ringing Ears	☐ Sinus Issues
☐ Stroke	☐ Thyroid Issues	☐ Chronic Fatigue	☐ Ear Infection	☐ Snoring	☐ Sleep Apnoea

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Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses in each category:

1. Physical Stress (falls, accidents, work postures etc.) _____

2. Biochemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol)

_____

3 Psychological or mental/emotional stress (work, relationships, finances, self-esteem etc)

_____

On a scale of 1-10 please rate your present levels of stress (including physical, biochemical and mental/emotional)

At work: At home: At play:

On a scale of 1-10 (1 = very poor and 10 = excellent) please rate your:

Eating habits: Exercise habits: Sleep: General Health: Mindset:

How do you grade your physical health (please tick):

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

How do you grade your mental/emotional health (please tick):

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

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Is there anything else which may help to better understand you, which has not been discussed?_____

Why are you here at this point in time? _____

CONSENT

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Name:_____ Sign:_____ Date: _____