

**CONFIDENTIAL PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

**Personal Details**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone: H) \_\_\_\_\_ W) \_\_\_\_\_ Mobile) \_\_\_\_\_

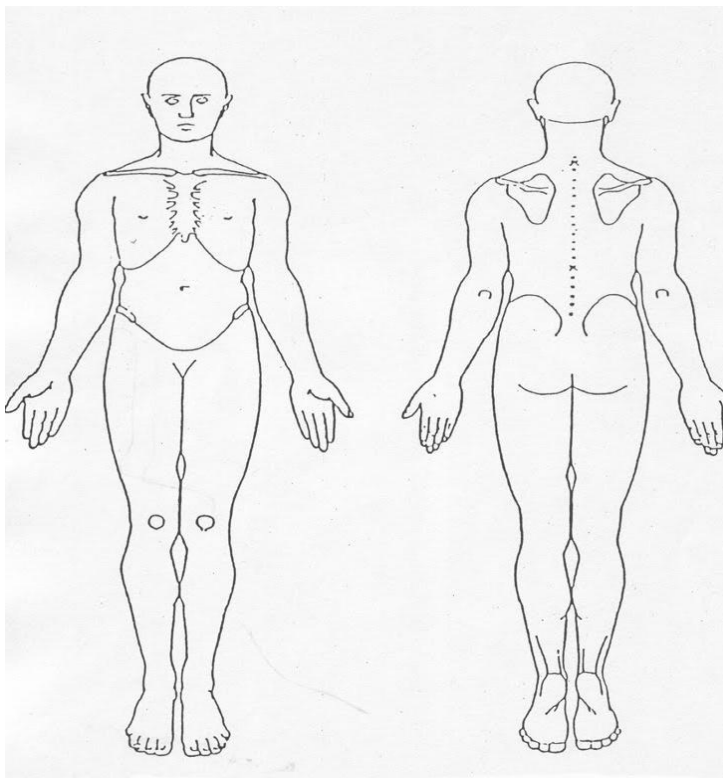
Occupation/Employer: \_\_\_\_\_

Who referred you to our centre?: \_\_\_\_\_

**Presenting Symptoms**

What is the purpose of this appointment (major complaint)? \_\_\_\_\_

Please use the diagram below to indicate the site of pain/problem



When did this problem begin? \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

What aggravates this condition? \_\_\_\_\_

What relieves your condition? \_\_\_\_\_

Is this condition (please circle) Worsening?            Constant?            Comes and Goes?

Is this condition interfering with (please circle) Work?            Sleep?            Daily Routine?

How long has it been since you felt really good? \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

**Medical History**

Have you ever had the same or similar condition? YES/NO    If yes, when? \_\_\_\_\_

(Please describe) \_\_\_\_\_

Have you lost any days from work (approximately how many)? \_\_\_\_\_

Have you seen other Doctors or Practitioners for this condition? \_\_\_\_\_

Have you been treated for any other health condition in the past year? YES/NO

Please describe \_\_\_\_\_

What operations have you had? \_\_\_\_\_

Have you had, or do you have any serious illnesses? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

If you are female, is there any possibility that you are pregnant? \_\_\_\_\_

Have you ever been under chiropractic care? YES/NO    From whom? \_\_\_\_\_

Do you currently, or have in the past suffered from any of the following? (Please circle)

- |                           |                     |
|---------------------------|---------------------|
| Headache                  | Low Back Pain       |
| Neck pain or stiffness    | Sciatica            |
| Asthma                    | Ear Noises          |
| Eye pain                  | Failing Vision      |
| Sinus infection           | High Blood Pressure |
| Low Blood Pressure        | Pain over heart     |
| Stroke                    | Chest pain          |
| Difficulty Breathing      | Constipation        |
| Bed wetting               | Frequent urination  |
| Prostrate trouble         | Cancer              |
| Irregular Menstrual Cycle |                     |

GP's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Name of Clinic: \_\_\_\_\_ Address \_\_\_\_\_

**Insurance Details**

Are you in a private health fund that covers you for chiropractic treatment? \_\_\_\_\_

Which fund? \_\_\_\_\_

Is the condition due to sickness or injury arising from your employment? \_\_\_\_\_

Have you ever been involved in a motor vehicle accident? YES/NO

Please give details \_\_\_\_\_

**Health Objectives:**

People consult with this office with one or more of the following objectives. Please indicate which apply to you. (Please underline)

- Relief of my symptoms
- Correction of my underlying problems
- To maximize my health

Signature: \_\_\_\_\_