Black Rock
CHIROPRACTIC CENTRE

CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____

Personal Details

Name:_____ **Date of Birth:**_____

Address:_____

Email Address:_____

Telephone: H)_____ **W)**_____ **Mobile)**_____

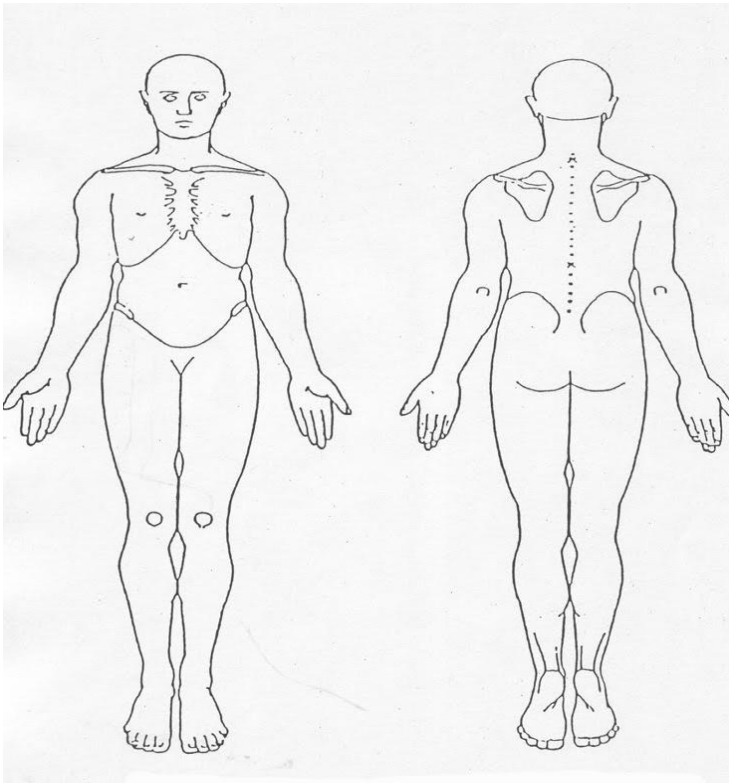
Occupation/Employer:_____

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?_____

_____

_____

<u>Medical History</u>

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_____

<u>Insurance Details</u>

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_____

<u>Health Objectives:</u>

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:_____