To enable us to assist you in reaching your health goals please complete the following.

Date: …….

Phone: (h) ……

Name: ……

(m) ……..

Address: ……
……..

(w)…….

Email: ……

Birth date: ……..

Age: ……

Occupation: ……

Who referred you to this centre? ……

What is your reason for consulting our clinic?
……
……..

When did this problem begin? ……..

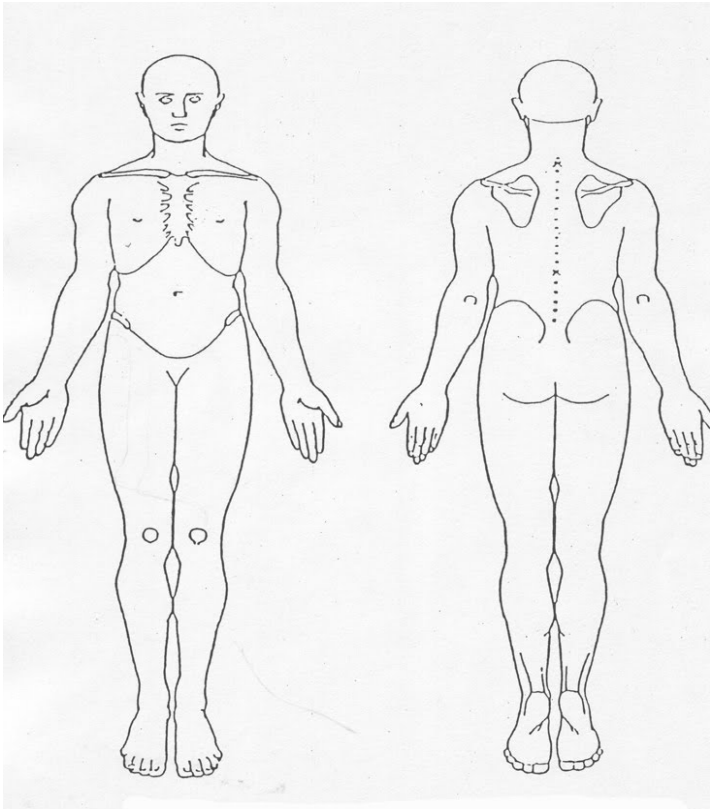
What aggravates the complaint? ……..

Have you seen any other practitioners for this complaint?.....

What relieves this complaint?
……

Have you had any musculo-skeletal conditions in the past? ……..

Please indicate the area of concern on the diagram below:



Have you had any surgery? Please list:
……

Do you suffer from any illness (Depression, Fibromyalgia, Parkinson's etc)?
……

Are you taking any medication? Please list and for what condition:…….
……..

Have you been involved in any major accidents? Please list…… .……

GP's Name: ……..

Clinic Name:…….

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

Headache	Lower 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	Hormonal Imbalance
Allergies	Acid Reflux

Signature……..