

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?

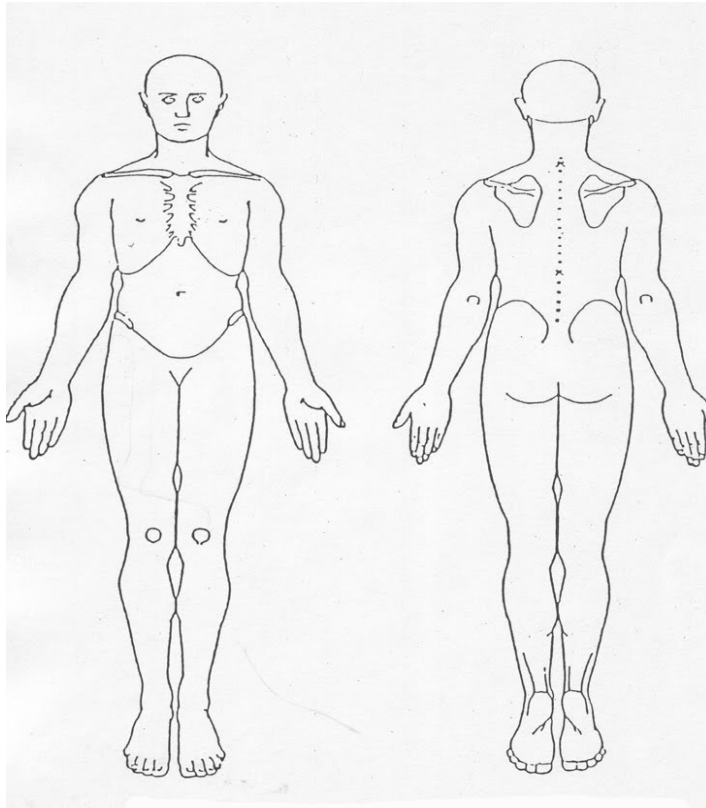
Have you seen any other practitioners for this complaint?.....

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.....