My purpose for seeking care in this practice is:

- ☐ Comprehensive health care for myself and my family
- ☐ Comprehensive health care for myself only
- ☐ Relief of my immediate symptoms only

Your consultation CANNOT begin until ALL questions have been answered to the best of your ability. Thank you.

Personal Details

Name: ______________________________ Mr. Mrs. Miss. Mst. Ms. Dr.

First Middle Surname

Address: ______________________________ Suburb: ______________

Postcode: __________ Phone: (H) __________ (Mob) __________ (W) __________

Date of Birth: __________ Age: ______ Married Single Divorced Widowed Defacto Separated

Occupation: __________ Employer & Address: ______________

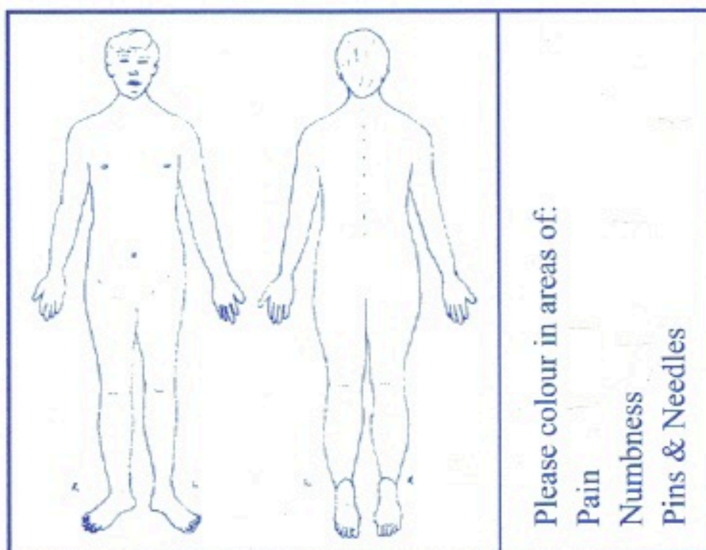
Next of kin: __________ Children: ______________

Who recommended you to the practice? ______________

E-mail address: ______________

Is this a work injury case? (Please circle) Yes No

Is this a transport accident case? (Please circle) Yes No



Previous Chiropractic Care

Name of Chiropractor: ______________

What were you being seen for? ______________

How many adjustments did you have? ______________

When was your last adjustment? ______________

Was your care: Excellent Satisfactory Unsatisfactory

Did the Chiropractor use x-rays? (Please circle) Yes No

Previous and Current Health

What is your reason for attending this practice? ______________

How long have you had this for? __________ What caused this? __________

Have you had this or similar in the past? __________ Does this complaint wake you at night? __________

What aggravates this condition? ______________

What relieves this condition? ______________

Is this complaint (Circle all relevant): Getting worse Constant Comes and goes

Is this complaint interfering with (Circle all relevant): Work Sleep Daily routine Other

List any previous diagnosis and care you have received for this complaint: ______________

Other Complaints? ______________

List any surgical operations and hospital stays: ______________

List all medications and reason for taking (eg. "The Pill" - birth control), health supplements or recreational drugs that you have used recently: ______________

Do you / or have you ever suffered from any health disorder or major illness? (i.e. diabetes, heart/lung disease, cancer, stroke, thyroid disease)

____

Is there a history of any of the above or other health disorders in your family? ______________________

____

Do you have good bladder control? ______________ Do you have good bowel control? ______________

Do you have good balance? ______________ Do you smoke? ______________

Medical Doctors name & address: ______________________

Have you ever been in a motor vehicle accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Description: include known or estimated speed of impact and angle of impact (front, side, rear, rollover): ______________

____

From a very young age when learning to walk and throughout the rest of our lives we experience literally hundreds of small accidents and traumatic events, please list and detail several of your most significant accidents or injuries: ______________

____

Other Symptoms: Please tick (✓) any of the conditions you have **NOW**. Please cross (✕) any of the conditions you have **had in the PAST**.

☐ Headache	☐ Cold sweats	☐ Numbness in toes	☐ Constipation
☐ Migraine	☐ Face flushed	☐ Numbness in fingers	☐ Muscle cramps
☐ Stiff neck	☐ Regular colds and flu	☐ Cold hands	☐ Back ache/pain
☐ Dizziness	☐ Tension	☐ Cold feet	☐ Painful /clicking jaw
☐ Vertigo	☐ Irritability	☐ Eczema	☐ Weight loss
☐ Loss of balance	☐ Fatigue	☐ Asthma	☐ Fever
☐ Blind spot in vision	☐ Depression	☐ Allergies	☐ Nausea
☐ Light bothers eyes	☐ Nervousness	☐ Chest pain	☐ Night pain
☐ Ears ring	☐ Loss of memory	☐ Shortness of breath	☐ Night sweats
☐ Loss of smell	☐ High blood pressure	☐ Diabetes	☐ Heavy legs
☐ Loss of Taste	☐ Low blood pressure	☐ Epilepsy	☐ Buckling/weak legs
☐ Difficulty swallowing	☐ Pins & needles in arms	☐ Diarrhoea	☐ Fainting/drop attacks
☐ Bad breath	☐ Pins & needles in legs	☐ Stomach upset	☐ Bowel/Bladder changes

Female

Are you pregnant? ☐ Yes ☐ No

☐ Menopausal symptoms	☐ Cramps or backache	☐ Hot flushes	☐ Congested breasts
☐ Excessive menstrual flow	☐ Lumps in breasts	☐ Irregular cycle	☐ Altered sex drive
☐ Painful menstruation	☐ Vaginal discharge	☐ Painful intercourse	

Male

☐ Prostate problems	☐ Impotence	☐ Altered sex drive	☐ Groin pain
☐ Pain in testicles	☐ Premature ejaculation	☐ Undescended testicles	

Please rate yourself by circling:

Pain Rating No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
Disability Rating Can do anything you want	0	1	2	3	4	5	6	7	8	9	10	Can't get out of bed
Stress Rating Low	0	1	2	3	4	5	6	7	8	9	10	High

What do you think is contributing to your stress? Work/Career Physical Stress Relationships Family Social Financial Emotional Stress Chemical Stress Other: ______________

To the best of my knowledge, the above is a true and accurate history. I understand that results from care cannot be guaranteed.
I have read and understand my financial obligations regarding this examination and any future care.

Signature: ______________________ Date: ______________