

**CONFIDENTIAL PATIENT INFORMATION**

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

**Personal Details**

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

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

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

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

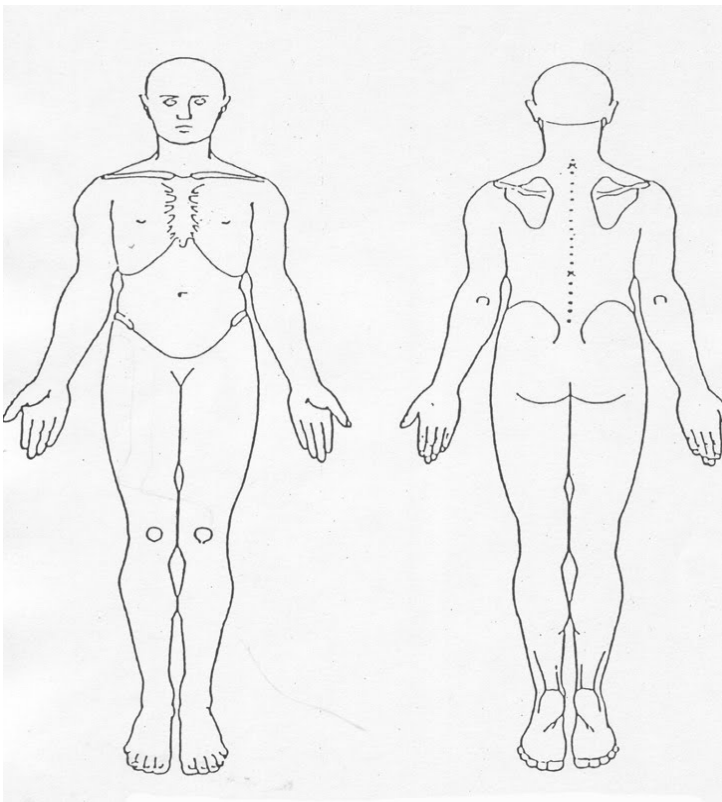
Occupation/Employer: \_\_\_\_\_

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 underline) Worsening?      Constant?      Comes and Goes?

Is this condition interfering with (please underline) 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 underline)

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
- To maximize myself, my family's and community's health

How would you rate your overall health? 1.....5.....10

What would you like your health to be? 1.....5.....10

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