Personal Information

Full Name _____Title _____ D.O.B _____ Age _____ Date _____

Address _____

_____ Postcode _____

Home Phone _____ Work Phone _____

Mobile _____ E-mail _____

Occupation _____ Employer _____

Gender _____ Single / Married / Divorced / Widowed/ Other _____ Children _____

Are you a member of a health fund that covers chiropractic? Yes / No / Unsure Name of fund _____

DVA no (if applicable) _____ Gold / White

How would you prefer appointment reminders? Email / SMS / No reminder

Emergency contact person _____ Phone no _____ Relationship _____

Who may we thank for referring you to our practice _____

Your Health Profile

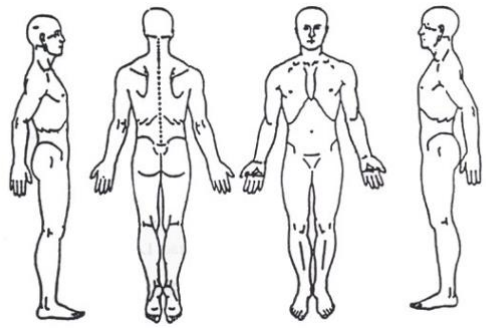
What is the purpose of your appointment today?

_____

_____

_____

Please mark any involved areas on the diagram below:



Where would you rate your current health?

1 _____ 5 _____ 10
Challenged Transitional Good Excellent

_____

Where would you like your health to be?

1 _____ 5 _____ 10
Challenged Transitional Good Excellent

_____

On a scale of 1-10 (1=very poor, 10=excellent) please describe the state of your:

Exercise _____ Sleep _____

Eating Habits_____ Pillow _____

Stress Level _____ Mattress _____

How many hours per day you spend at a desk _____

Please tick the appropriate box and give details where required

Do/did you smoke? ❒ Yes ❒ No _____

Do/did you drink alcohol? ❒ Yes ❒ No _____

Do you wear orthotics or heel lifts? ❒ Yes ❒ No _____

Is the condition of your health interfering with your:

❒ Work ❒ Exercise/Sport ❒Walking ❒ Leisure/Hobbies ❒ Sleep ❒ Positive Mental Attitude

❒ Other _____

General History

Please list any accidents, injuries or falls, including motor-vehicle accidents, work-related accidents, sports injuries or otherwise:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Please list any surgery you have had and when:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Please list any medications (prescription and non-prescription), vitamins or supplements you are taking and why: _____

_____

_____

Have you ever had X-Rays taken? _____ **If yes, what area of your body, and when?**_____

_____

Please indicate if you have/have had any of the following conditions:

❒ Heart Disease	❒ Diabetes	❒ Aneurysm	❒ High blood pressure/cholesterol
❒ Stroke	❒ Cancer	❒ HIV/AIDS	❒ Epilepsy
❒ Osteoporosis	❒ Arthritis	❒ Asthma	

Please indicate if you have/have had any of the following symptoms in the last 12 months:

❒ Back or neck pain/stiffness	❒ Headache	❒ Fatigue	❒ Sleeping problems
❒ Indigestion	❒ Nausea/Vomiting	❒ Anxiety	❒ Depression
❒ Bowel or bladder problems	❒ Blurred vision	❒ Difficulty breathing	❒ Chest pain
❒ Menstrual pain/irregularity	❒ Allergies	❒ Fever	❒ Ringing in ears
❒ Dizziness/Loss of balance	❒ Numbness/Pins and needles	❒ Convulsions/Seizures	❒ Cold hands or feet

Consent

I have read and agree that all information provided is accurate to the best of my knowledge. I also agree that it is my responsibility to inform the chiropractor if any of the above information changes. I consent to a consultation and examination to determine if I should be under chiropractic care.

Signature: _____ Date: _____

Thank you for taking the time to complete this form!