

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:			
Street	Suburb	State	Postcode
Home phone:		Work phone:	
Mobile:		Email address:	
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital status: M S W D		Spouse/guardian name:	
Occupation:			

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Other doctors you have seen for this condition:

Chiropractor	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
-------------------------------	--------------------------------	--	--	--

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	3.Type:	When?
2. Type:	When?	4.Type:	When?

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
---------------	-------	--------

Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs/vitamins/nutritional supplements you have taken in the past 6 months and why: (prescription and non-prescription)

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

- 1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

- 2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

- 3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
----------	----------	----------

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
----------------	------------------	--------	-----------------	-----------

How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
------------------------------------	-------------------------------	-------------------------------	-------------------------------	---	--

How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
------------------------------------	-------------------------------	-------------------------------	-------------------------------	---	--

Is there anything else which may help to better understand you which has not been discussed?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____