Confidential
Patient Information

Personal Information

Who may we thank for referring you? _____

Full name:		**Date:**
Address:	**Suburb:**	**Post Code:**
Phone: Home:	**Mobile:**	**Work:**
Email address:		
Date of birth:	**Occupation:**	
Marital status: M S W D	**Partners name:**	**Pregnant? Yes ☐ No ☐**
Names & ages of children:		
Private Health Fund:		
Doctors name & address:		

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.					

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?

_____

_____

Which activities aggravate your condition? _____

_____

What makes your condition feel better? _____

_____

Other doctors you have seen for this condition:_____

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 ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐(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?
2. 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 ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Past Health History

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

☐Alcoholism	☐Allergy	☐Anemia	☐Arteriosclerosis	☐Arthritis	☐Asthma	☐Back Pain
☐Cancer	☐Cold Sores	☐Constipation	☐Convulsions	☐Depression	☐Diabetes	☐Diarrhea
☐Eczema	☐Emphysema	☐Epilepsy	☐Gall Bladder Problems	☐Gout	☐Headaches	☐Heart Attack
☐Heart Disease	☐High Blood Pressure	☐HIV (Aids)	☐Irregular Periods	☐Low Blood Sugar	☐Malaria	☐Measles
☐Menstrual Cramps	☐Migraines	☐Miscarriage	☐Multiple Sclerosis	☐Sinus Problems	☐Neck Pain	☐Nervousness
☐Irritable Bowel Syndrome	☐Pleurisy	☐Pneumonia	☐Polio	☐Rheumatic Fever	☐Ringing in ears	☐Anxiety
☐Stroke	☐Thyroid Problems	☐PMS	☐Ulcers	☐Venereal Disease	☐Whooping Cough	

Other (please explain) _____

Current Medicines and Supplements

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

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Are you interested in knowing more about how your nutrition affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would you help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

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 ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and or spouse checked for subluxations tick the box below and they can receive a complimentary examination if scheduled within 2 weeks of you starting care. **This exam is no cost to you** and does not obligate them to receive further care. We have several convenient and affordable family plan payment options should family members decide to receive care.

☐ I would like my family members checked for subluxations in the next 2 weeks.

DON'T MISS OUT

At Chiro4FamilyWellness we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know. I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns they can be discussed with my chiropractor. I appreciate that I will receive the best care possible at this office, but that results cannot be guaranteed.
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.

Patient signature …… Date ….. / ….. / …….. Witness……..