Date _____________ Patient File No. ________

Name ____ Birth date _____________

Address ______________________________ Suburb _______________ P/C _______

Email ____________________________________ Occupation ____________________

Home Phone _____________ Work Phone _____________ Mobile __________________

Emergency contact person & phone number ______________________________________

Do you have private health insurance? Yes ☐ / No ☐ If yes, which company? _____________

How did you hear about our office? ___________________ Are you a senior? Yes ☐ / No ☐

Are you a Centrelink card holder? Yes ☐ / No ☐ Expiry date: ____ / ____

Current concern:

What is your primary health concern today? ______________________________________

Location of pain: __________________ Does it radiate? To where? ___________________

What caused this pain/injury/symptom? ____

Is this a Workers' Compensation claim? Yes ☐ / No ☐ A Motor Vehicle Claim? Yes ☐ / No ☐

Have you had this same type of problem in the past? Yes ☐ / No ☐ When? ______________

How long ago did this current bout begin? ___________________

Frequency of bouts: _____________________ Duration of bouts: _____________________

On a scale of '0-10' (0 = no pain, 10 = terrible pain), how bad is your pain currently? _________

Is the problem getting .... Worse? ☐ Better? ☐ Staying constant? ☐ Coming & going? ☐

What increases the pain? ________________ What decreases the pain? ________________

What prior treatment have you had for this issue? ____________________________________

What was the diagnosis? _______________ And outcome of treatment? _______________

How long ago was your last chiropractic visit? _______________

Notes: ____

Have you had or do you have problems with any of the following?

	Past	Present	No		Past	Present	No
Headaches/migraines	☐	☐	☐	Lung problems	☐	☐	☐
Eyes (other than glasses)	☐	☐	☐	Asthma/breathing trouble	☐	☐	☐
Ears (tinnitus, etc)	☐	☐	☐	Sleeping/insomnia	☐	☐	☐
Dizziness/vertigo	☐	☐	☐	Anxiety	☐	☐	☐
Nose / sinuses	☐	☐	☐	Depression	☐	☐	☐
Throat	☐	☐	☐	Diabetes	☐	☐	☐
Fatigue	☐	☐	☐	Epilepsy/convulsions	☐	☐	☐
Heart burn / indigestion	☐	☐	☐	Stroke	☐	☐	☐
Constipation	☐	☐	☐	Heart attack	☐	☐	☐
Diarrhoea	☐	☐	☐	High/low blood pressure	☐	☐	☐
Bladder problems	☐	☐	☐	Heart problems	☐	☐	☐
				Cancer	☐	☐	☐
Pain or weakness or numbness in hands/feet/arms/legs	☐	☐	☐	Allergies	☐	☐	☐

Please list your current ... Height __________ Weight __________ Blood Pressure __________

Have you had any of the following in the past?

	Yes	No		Yes	No
Car accident / whiplash	☐	☐	Other surgery	☐	☐
concussion, knocked unconscious	☐	☐	Hospitalisation	☐	☐
Falls (i.e. from a tree, down stairs, etc)	☐	☐	Significant sports-injuries	☐	☐
Removal of gallbladder, appendix, tonsils, &/or wisdom teeth, etc?	☐	☐	Fractured or broken bones	☐	☐
			Any other serious health issues	☐	☐

Do you have a 'family history' of any of the following?

	Yes	No		Yes	No
Arthritis	☐	☐	Cancer	☐	☐
Heart disease	☐	☐	Diabetes	☐	☐
Stroke	☐	☐	Other	☐	☐

Do you currently do any of the following?

	Yes	No		Yes	No
Take any prescription medications	☐	☐	Smoke more than 10 cigarettes per week	☐	☐
Drink more than 10 alcoholic beverages per week	☐	☐	Perform 30 minutes of vigorous exercise at least twice per week	☐	☐
Regularly go to the toilet 3 or more times per night	☐	☐			

It is the responsibility of the patient to make it known whatever he/she is suffering from, such as latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractor.

By signing below, I declare that "the answers I have provided above are true, accurate, and complete to the best of my knowledge. I have not withheld any health information. Any questions that I did not answer were not applicable."

____ _______________

Patient’s signature (or guardian signature, if under 18) Date

Chiropractor's Additional Notes:

____

Chiropractor’s signature