**Confidential Patient Information**



**Dr………………………………………… Date:……………………..**

**Name: Mr. / Mrs. / Miss Home Phone:**

**Address: Work Phone:**

**Suburb: P/Code: Mobile Phone:**

**DOB: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ M/F \_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Spouse (or parent, if minor) and DOB: Please Indicate €**

**Name/s of Children and DOB:**

|  |  |
| --- | --- |
| **Referred By** | **Concession** |
| **€ Friend/Relation** | **€ Pension Card** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **€ Student Card** |
| **€ Yellow Pages** | **€ Health C Card** |
| **€ Drive/Walk By** | **€ Child U 18** |
| **€ Other** | **€ Workcover** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **€ DVA** |

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employed by:**

**Who Is Responsible For Account?**

**Do You Have Health Insurance? Y / N What Company?**

**Is Your Present Condition Covered By Workers Compensation? Y / N**

**Emergency Contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Patient Case History**

**Dear Patient: Please complete this questionnaire. Your answers will help us to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.**

**THIS IS A CONFIDENTIAL HEALTH REPORT**

**CHECK OFF ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR HAVE**

**PLEASE TICK**

|  |  |  |
| --- | --- | --- |
| **GENERAL** | **GASTRO-INTESTINAL** | **RESPIRATORY** |
| * **Allergy** | * **Belching or gas** | * **Chest pain** |
| * **Dizziness** | * **Colon trouble** | * **Chronic cough** |
| * **Fatigue** | * **Constipation** | * **Difficult breathing** |
| * **Headache** | * **Diarrhea** | * **Asthma** |
| * **Loss of sleep** | * **Difficult digestion** |  |
| * **Nervousness/depression** | * **Gall bladder trouble** | * **SKIN** |
| * **Numbness** | * **Hemorrhoids** | * **Bruise easily** |
|  | * **Liver trouble** | * **Dryness** |
| **MUSCLE AND JOINT** | * **Nausea** | * **Itching** |
| * **Low back pain** | * **Poor appetite** | * **Psoriasis** |
| * **Neck pain or stiffness** | * **Hiatus Hernia** |  |
| * **Pain between shoulders** |  | **GENITO-URINARY** |
| * **Swollen joints** | **EYES, EARS, NOSE & THROAT** | * **Bed wetting** |
| * **Arm pain** | * **Earaches** | * **Frequent urination** |
| * **Leg pain** | * **Enlarged glands** | * **Painful urination** |
| * **Knee pain** | * **Eye pain** | * **Kidney infection** |
| * **Foot pain** | * **Sinus problems** | * **Prostate trouble** |
| * **Ankle pain** | * **Blurred vision** | * **Testicular pain** |
| * **Hand pain** | * **Hearing loss** |  |
|  |  |  |
| **WOMEN ONLY** | **CARDIO-VASCULAR** |  |
| * **Excessive menstrual flow** | * **Blood pressure** |  |
| * **Irregular cycles** | * **Poor circulation** |  |
| * **Painful menstruation** | * **Rapid heart beat** |  |
| * **Vaginal discharge** | * **Slow heart beat** |  |
| * **Ovarian cysts** | * **Swelling of ankles** |  |
| * **Fibroids** |  |  |
| * **Thrush** |  |  |

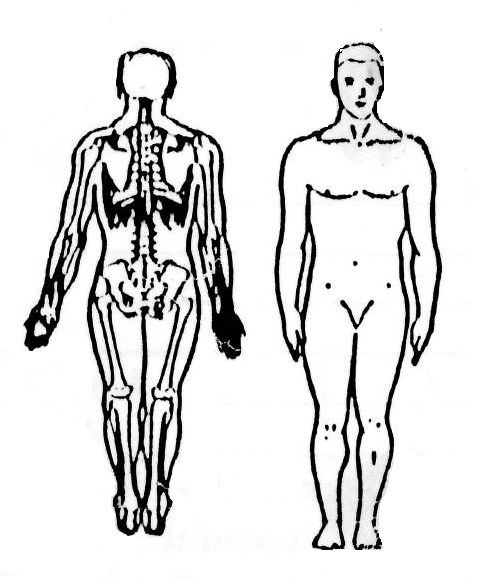
**Have you been in an auto accident? € Past year € Past 5 years € Over 5 years € Never**

**Describe**

**Have you had chiropractic care before? Y / N When ?**

**Where? By Dr.**

**What is your major complaint? Please Illustrate affected areas**



**How long have you had this condition?**

**Have you had this or similar conditions in the past?**

**What activities aggravate your condition?**

**Is this condition getting progressively worse? € Yes € No € Constant € Comes and goes**

**Is this condition interfering with your: € Work € Sleep € Daily routine € Other**

**Other complaints**

**How long has it been since you felt good?**

**List surgical operations and years:**

**Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date:**

**Exercise programs & sports**

**Your Medical Dr. is**

**FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses, thus information about your family members will give us a better picture of your total health picture.)**

|  |  |  |
| --- | --- | --- |
| Examination | Date: | |
|  | L | R |
| **Posture** |  |  |
| Bilateral Scales |  |  |
| Ears |  |  |
| Shoulders |  |  |
| Hips |  |  |
| Body Lean |  |  |
| Head Lean |  |  |
| Ant. Head |  |  |
| **Neck Motion** |  |  |
| Flexion 65 |  | |
| Extension 65 |  | |
| Lat. Flex. 45 |  |  |
| Rotation 90 |  |  |
| **Lumbar Motion** |  |  |
| Flexion 90 |  | |
| Ext / Kemps 35 |  | |
| **Muscle Strength** |  |  |
| Deltoid |  |  |
| Grasp |  |  |
| Pinch |  |  |
| Psoas |  |  |
| SLR |  |  |
| Leg Length |  |  |
| Leg Lift Prone |  |  |
| Static Palp |  | |
| Heal Toe Test |  | |
| Visual A. S. |  |  |
| Other |  | |
| Follow up WL |  | |
|  |  | |

|  |  |  |
| --- | --- | --- |
| **NAME** | **RELATION** | **PAST & PRESENT HEALTH PROBLEMS** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE OF LAST** | **Less than 6 months** | **6-18 months** | **Over 18 months** | **Never** |
| **Spinal examination** |  |  |  |  |
| **Physical examination** |  |  |  |  |
| **Blood test** |  |  |  |  |
| **Chest x-ray** |  |  |  |  |
| **Spinal x-ray** |  |  |  |  |
| **Dental x-ray** |  |  |  |  |
| **Urine test** |  |  |  |  |

**DO YOU:**

**Now take vitamins or minerals?**

**Describe**

**Now take drugs of any kind?**

**Describe**

|  |
| --- |
| **PLEASE DO NOT WRITE BELOW THIS SPACE** |