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

Please Indicate

Referred By	Concession
Friend/Relation	Pension Card
__________	Student Card
Internet	Health C Card
Facebook	Child U 18
Other	DVA
__________	EPC

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
- Allergy
- Dizziness
- Fatigue
- Headache
- Loss of sleep
- Nervousness/depression
- Numbness

MUSCLE AND JOINT
- Low back pain
- Neck pain or stiffness
- Pain between shoulders
- Swollen joints
- Arm pain
- Leg pain
- Knee pain
- Foot pain
- Ankle pain
- Hand pain

WOMEN ONLY
- Excessive menstrual flow
- Irregular cycles
- Painful menstruation
- Vaginal discharge
- Ovarian cysts
- Fibroids
- Thrush

GASTRO-INTESTINAL
- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Gall bladder trouble
- Hemorrhoids
- Liver trouble
- Nausea
- Poor appetite
- Hiatus Hernia

EYES, EARS, NOSE & THROAT
- Earaches
- Enlarged glands
- Eye pain
- Sinus problems
- Blurred vision
- Hearing loss

CARDIO-VASCULAR
- Blood pressure
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY
- Chest pain
- Chronic cough
- Difficult breathing
- Asthma

SKIN
- Bruise easily
- Dryness
- Itching
- Psoriasis

GENITO-URINARY
- Bed wetting
- Frequent urination
- Painful urination
- Kidney infection
- Prostate trouble
- Testicular pain

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? ____________________________________

____

____

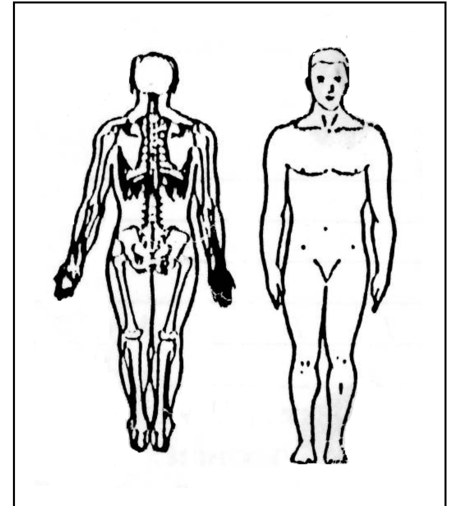
____

____

____

____

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.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

DO YOU:

Now take vitamins or minerals? _______

Describe ____________________________________

____

Now take drugs of any kind? __________

Describe ____________________________________

____

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				

PLEASE DO NOT WRITE BELOW THIS SPACE

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		