PERSONAL DETAILS

Name: …………………………… ……………………… ………………………………………..…..
First Middle Surname

Address: ……………………………………………………………………………………………………..………

Suburb……………………..…………………… Postcode: ………….……… Email: ……………………………………

Phone: (Work) ……………………….....….. (Home) ……………….....……....…….. (Mobile) ……………………......……..

Date of birth: ……………………………….. Age: ………..…… Male ☐ Female ☐

Occupation: …………………………………………… Employer: ……………………………………………………..

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Defacto ☐ Separated ☐

Spouses/Parents name: ………………………………………………. Children: …………………..………..……………

Who recommended you to this clinic? ……………………………………...……………………………………………

Are you a member of a Health Fund that covers Chiropractic Care? Yes ☐ No ☐ Don't Know ☐

Is this a work injury case? Yes ☐ No ☐ Is this a Transport Accident case? Yes ☐ No ☐

IF YOU HAVE EVER HAD CHIROPRACTIC CARE BEFORE, PLEASE COMPLETE THE FOLLOWING

Name of Chiropractor ……………………………..……..………… Located where? ...……………………………….………

What were you being treated for? ……………………………………...………………………………………...…

How many treatments were given? ……………………… and how frequent? ………………….……………………………...

When was your last treatment? …………………………………………………………………………………………..

What were the results of your treatments: Excellent ☐ Satisfactory ☐ Fair ☐ Did Not Help ☐ Got Worse ☐

Did the Chiropractor use X-Rays? Yes ☐ No ☐

PREVIOUS AND CURRENT HEALTH

What is your major complaint? ……………………………………..…………………………..………………………

Other Complaints? ……………………………………………………………………………………..……………………..

How long have you had this complaint? ………………………………………………………..…...………………………

Have you had this or a similar complaint in the past? ………………………………………………....…………………...

What activities aggravate your complaint? …………………………………………………………...……………………

Is this complaint getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Is this complaint interfering with your Work ☐ Sleep ☐ Daily Routine ☐

Other………

List previous diagnosis and treatments you have received for present complaint ……………………………………….……

…….

List surgical operations and years ………………………………………………………………………………………………..

Drugs you now take: Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-Inflammatories ☐

Tranquillisers ☐ Birth Control Pills ☐ Blood Pressure ☐ Other ….………………………………………………

Dental visits: Every Six Months ☐ Yearly ☐ Toothache/Emergency Only ☐ Complete Dentures ☐

Are you wearing: Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐

Have you been in a Motor Vehicle Accident: Past Year ☐ Past Five Years ☐ Over Five Years ☐ Never ☐

Any other Accident (Describe) ....……………………………..……………...….

…….

Signature: ……………………………….. **Date: …………………………………**