X-RAYS: / /
Cons. signed

Full Name: Mr / Mrs / Ms / Miss _____

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

Address: _____ Suburb:_____ Postcode: _____

Contact Phone Nos: (*H*): _____ (*Mob*):_____ (*W*): _____

Email: _____ **Date of Birth:** ___ / ___ / ___ Age: _____

Your Occupation: _____

Are you aged 65 or over? *Yes* ☐ *No* ☐ Are you on a Disability Pension? *Yes* ☐ *No* ☐

Are you a member of a Health Fund? *Yes* ☐ *No* ☐ How did you hear about us? _____

Is this a work injury case? *Yes* ☐ *No* ☐ Is this a transport accident case? *Yes* ☐ *No* ☐

Spouse/Next of Kin's Name: _____ Number of Children: _____

If you have ever had chiropractic care before, please complete the following -

Name of chiropractor: _____

What were you treated for?_____

What was your frequency of care?_____

When was your last visit? _____

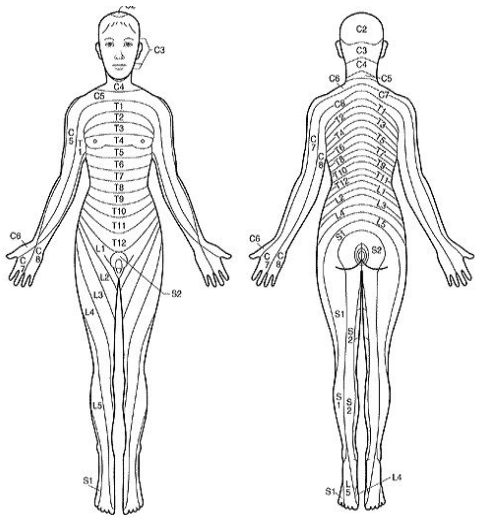
Were the results of the treatment? *Excellent* ☐ *Satisfactory* ☐ *Unsatisfactory* ☐

Have you had x-rays of your spine taken? *Yes* ☐ *No* ☐

Please colour in - ***areas of pain*** *in* ***red***

areas of numbness *in* ***blue***

areas with pins & needles *in* ***black***



Previous and Current Health

What is your major complaint? _____

Any other complaints? _____

How long have you had this complaint? _____

Have you had this or a similar complaint previously?

_____

What activities aggravate this complaint?

_____

Is the complaint getting - *Worse* ☐ *Staying the same* ☐ *Comes and Goes* ☐

Is the complaint interfering with your - *Work* ☐ *Sleep* ☐ *Daily routine* ☐ *Other* ☐ _____

On a scale of 1 to 10, with 10 being the worst, please circle your level of pain - *1 2 3 4 5 6 7 8 9 10*

List previous diagnosis and treatments you have received for your complaint:

_____

List surgical operations and when: _____

Are you pregnant? (*females only*) *Yes* ☐ *No* ☐

Are you taking any of the following medications? *Nerve pills* ☐ *Pain Killers* ☐ *Muscle relaxants* ☐

Anti-inflammatory ☐ *Tranquilizers* ☐ *Birth control* ☐ *Blood pressure* ☐ *Anti-depressants* ☐

Medical doctor's name and address: _____

Have you been in a motor vehicle/bike accident: *Past year* ☐ *Past 5 years* ☐ *Over 5 years* ☐ *Never* ☐

Or any other accident (describe) _____

_____ Signature ____ / ____ / ____ Date

PATIENT HEALTH QUESTIONNAIRE

To help your chiropractor better assess your overall health status, please complete the following.
Tick (☑) under the appropriate heading for any specific conditions/symptoms which apply to you.
If you tick "**Other**" for any section, please specify condition/symptom.

O = Occasionally F = Frequently C = Constantly

Musculo-Skeletal Symptoms	Neck			Upper/Mid Back			Lower Back		
	O	F	C	O	F	C	O	F	C
Pain/Ache									
Stiffness / Restricted Mobility									
Clicking/Grating Sensation									
Other:									

Extremities	Shoulders/Arms/Hands			Legs/Feet		
	O	F	C	O	F	C
Stiffness/Restricted Mobility						
Loss of Strength						
Pins and Needles/Numbness						
Swollen Joints						
Other:						

GENERAL HEALTH

Head	O	F	C
Headache			
Sinus			
Dizziness			
Ringing in Ears			
Other:			

Chest	O	F	C
Pain/angina			
Asthma/Wheezing			
Shortness of Breath			
Other:			

Stomach/Abdomen	O	F	C
Pain/ache			
Heartburn Reflux			
Stomach Ulcer			
Hernia			
Liver Disease/Gall Bladder			
Colic			
Diarrhoea			
Bladder/Kidney Infection			
Bed Wetting/incontinence			
Painful Urination			
Difficulty in starting urination			
Prostate Trouble			
Other:			

General Symptoms	O	F	C
Allergies			
Convulsions/Epilepsy			
Excessive Fatigue			
Fevers			
Sudden Weight Change			
Poor Sleep			
Nervousness			
Depression			
Tremors			
Poor Circulation			
Low/High Blood pressure			
Other:			

Female Only	O	F	C
Period pain			
Irregular Periods			
Bleeding between periods			
Changed menstrual flow			
Hot Flushes			
Menopausal Symptoms			
Other:			

Family History	Yes	No
Strokes		
High blood pressure		
Diabetes		
Heart Attack		
Have you at any time been diagnosed with cancer?	**Yes**	**No**

Patient's Signature: _____ **Date :** _____ / _____ / _____