

X-RAYS: / /

Cons. signed

Full Name: _____

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

Suburb: _____ **Postcode:** _____ **Contact Phone Nos: (H):** _____

(Mob): _____ **Email:** _____

Full Name of Parent/Guardian/Carer: _____

Relationship to Patient: _____

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

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

Name of chiropractor: _____

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

What were you treated for? _____

areas of numbness in blue

What was your frequency of care? _____

areas with pins & needles in black

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

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 & 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) _____

Parent/Guardian/Carer Signature _____ / _____ / _____ Date

I UNDERSTAND THAT ALL RECORDS ARE KEPT CONFIDENTIAL AND I CERTIFY THAT THE INFORMATION I HAVE PROVIDED HERE IS TRUE TO THE BEST OF MY KNOWLEDGE. I hereby authorize Ansell Chiropractic to administer Chiropractic care as deemed necessary to this minor child.

