Confidential History

Date ____________________

Full name ____ Preferred Name ____________________

Address ____ D.O.B. ____________________

Town/Suburb ____ Mobile no. ____________________

Email ____ Home no. ____________________

Occupation ____ Work no. ____________________

GP name ____ DVA no. ____________________

Referrer ____ Health Fund ____________________

Emergency Contact ____ Emergency Contact no. ____________________

Reason(s) for consulting us today (include any known cause e.g. accidents, duration of the problem, type of pain, other treatments/therapies received)

Medical history (include all health conditions/diagnoses, medications, hospitalisations, surgeries, accidents/injuries, major dental work)

Please describe any **significant emotional trauma or stress** you have experienced that you consider may be contributing to your presentation

Natural products (include vitamin supplements, homeopathics and any other natural products currently used)

Do you suffer from any condition other than that for which you are now consulting us or have any other information that we would reasonably need to know to provide you with safe, effective care? ○ Yes ○ No

Please describe ____

We assure that all reasonable measures will be taken in keeping with our Privacy Policy and legislative requirements to ensure the personal information and identity details we hold remain protected and secure.

Confidential History (cont.)

Name ______________________________

Previous Chiropractic care? ○ Yes ○ No With Dr ______________________________

Where? ______________________________ When? ______________________________

Have you been under regular Chiropractic care? ○ Yes ○ No If so, how frequently? ______________________________

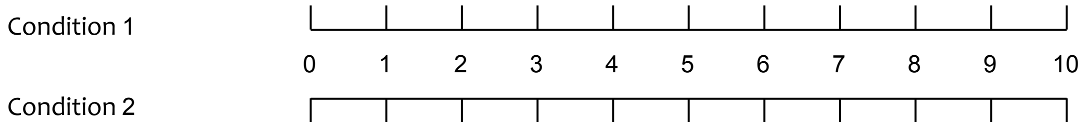
Recent X-rays/CT/MRI scans (in last 5 years)? Yes/No Findings ______________________________

Have you ever:

Smoked?	Yes/No	If so, how long? ________	Currently?	Yes/No	How much? ________
Used "recreational" drugs?	Yes/No	If so, how long? ________	Currently?	Yes/No	How much? ________
Consumed alcohol?	Yes/No	If so, how long? ________	Currently?	Yes/No	How much? ________
Drunk coffee?	Yes/No	If so, how long? ________	Currently?	Yes/No	How much? ________

Please indicate your current level of pain or discomfort with a cross (X): (0 = no pain, 10 = worst ever pain)

Condition 1



Condition 2

Our goal is to help you to be the healthiest you that you can be. To help us identify where you are currently and how far you would like us to assist you to become your 'best you', please indicate the following:

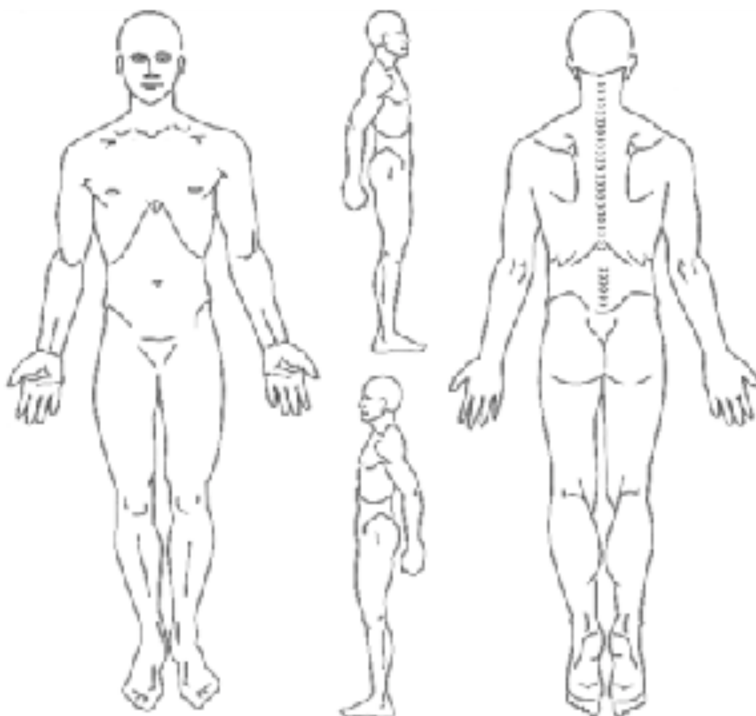
1. your current overall health position on the following scale with an '+',
2. where you normally would consider your health to be with an 'O', and
3. where you would ideally like to be with an 'X'.

Worst ever No pain, but not great Best ever

-10 -8 -6 -4 -2 **0** 2 4 6 8 **10**

Health position:

Please indicate on the following diagram where there is presently, or recently has been, pain or discomfort



Clinical use only:

Adam's Test

FHP

Antalgia R L

Coxa varus R L

Coxa valgus R L

Genu varus R L

Genu valgus R L

O'pronation R L

Cx:

Lx:

I declare that the information provided on this form is true and correct to the best of my knowledge.

Name: ______________________________ as Parent/Guardian for ______________________________

Signed: ______________________________ Date: ______________________________

We assure that all reasonable measures will be taken in keeping with our Privacy Policy and legislative requirements to ensure the personal information and identity details we hold remain protected and secure.