



Chiropractic | Osteopathy | Psychology | Massage

CLIENT INFORMATION

Dr Robert Waters
Chiropractor | Osteopath

Dr Brad Jones
Chiropractor

Dr Darren Riordan
Chiropractor

Samantha Waters
Psychologist

Surname: _____ Given Names: _____

Address: _____

Telephone: (Hm) _____ (Mob) _____ (Wrk) _____

Email: _____ Age: _____ DOB: _____

Sex: M / F Marital Status: _____ Spouse / Partner's Name: _____ No. of Children: _____

Occupation / Sports / Leisure Activities: _____

How did you learn about us? Friend / Family * [] Doctor * []

Yellow Pages (book / online) [] Local Search []

Internet Search (eg Google, Yahoo)[] Shop Signage []

Please provide name of referring person * _____

COMPLAINT HISTORY

Reason for Consultation: _____

MEDICAL HISTORY

Your current Medical Doctor: _____

DO YOU SUFFER FROM ANY ILLNESSES? YES / NO

If yes, please describe: _____

ARE YOU TAKING ANY MEDICATIONS? YES / NO

If yes, please describe: _____

HAVE YOU HAD ANY OPERATIONS? YES / NO

If yes, please describe: _____

HAVE YOU HAD ANY MAJOR ACCIDENTS? (Motor vehicle, other) YES / NO

If yes, please describe: _____

HAVE YOU HAD ANY FRACTURES, DISLOCATIONS OR BROKEN BONES? YES / NO

If yes, please describe: _____

IS THERE A FAMILY HISTORY OF ILLNESS? YES / NO

If yes, please describe: _____

ARE YOU A SMOKER? YES / NO No. PER DAY? _____

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING IN THE LAST 6-12 MONTHS? (please tick)

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Pain in shoulder / arm / hand | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Numbness in arm / hand | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hayfever |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Gallbladder conditions |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Digestion problems |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Recurring constipation and/or diarrhoea |
| <input type="checkbox"/> Menstrual problems, cramps | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness in legs | <input type="checkbox"/> Leg cramps, cold feet |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stress |

SIGNATURE: _____

DATE: _____