MUDGEERABA Chiropractic

Dr Robert Waters
Chiropractor | Osteopath

Dr Brad Jones
Chiropractor

Samantha Waters
Psychologist

Chiropractic | Osteopathy | Psychology | Massage

Client No. 2016

Surname: _____ Given Name: _____

Address: _____

Telephone – Home: _____ Mobile: _____

Age: _____ DOB: _____ Occupation: _____

Email: _____

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

Yellow Pages [ ] Shop Signage [ ]

Internet Search (Google / Website) [ ]

Please provide name of referring person * _____

PRESENTING PROBLEM

Reason for Consultation: _____

Is the pain Sharp [ ] Dull [ ] Constant [ ] On and Off [ ] Other [ ] _____

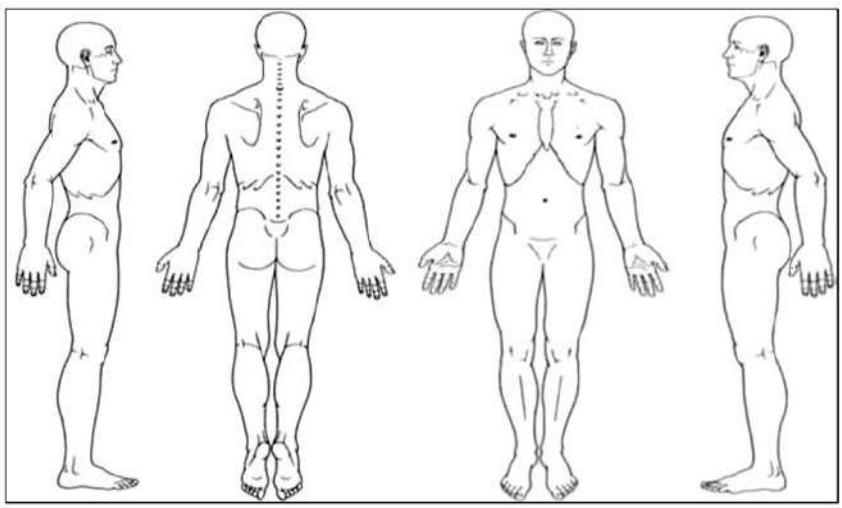
Did this occur as the result of a trauma / incident? YES / NO

If yes, please describe: _____

Do you have any other symptoms associated with your complaint or any other health problems? YES / NO

If yes, please describe: _____

Please mark the affected area on the diagram below: Use this space for any additional information:



MEDICAL HISTORY

Do you suffer from any **illness or disease**? YES / NO

If yes, please describe: _____

Are you taking any **medications**? YES / NO

If yes, please describe: _____

Have you had any **surgeries / operations**? YES / NO

If yes, please describe: _____

Have you had any major accidents, resulting in **broken bones or dislocations**? YES / NO

If yes, please describe: _____

Is there family history of illness such as **heart disease, stroke, high/low blood pressure, diabetes or cancers**?

YES / NO If yes, please describe: _____

Are you a smoker? YES / NO If yes, how many per day_____

Do you regularly consume alcohol? YES / NO If yes, how many per day_____

Do you suffer from any of the following illnesses? (please tick)

- □ Headaches / Migraines
- □ Fainting / Seizures
- □ Numbness in arms or legs
- □ Shortness of breath
- □ Kidney problems
- □ High / Low blood pressure
- □ Bladder problems
- □ Constipation and/or diarrhoea
- □ Night sweats / Fever
- □ Stroke
- □ Dizziness / Lightheaded
- □ Vertigo
- □ Fatigue
- □ Asthma
- □ Heart conditions
- □ Stomach problems
- □ Irritable bowel
- □ Pain at night
- □ Jaw pain
- □ Unexplained weight loss

SIGNATURE: _____

DATE: _____