Bangalore Chiropractic & WELLNESS CLINICS™
NATURAL HEALTHCARE SOLUTIONS

HEALTH QUESTIONNAIRE

Patient ID:_____

Patient Information

Name: _____ Sex: _____ Age: _____
Given Names Surname

Address:_____
_____
_____ Suburb: _____ Postcode: _____

E-mail Address: _____ Marital Status: _____

Phone/Mobile : _____ Birth Date: _____
DD / MM / YYYY

Occupation: _____ No. & Age of Children: _____

Who recommended you to this Clinic? _____

What language(s) do you speak? _____

Health History:

If you have suffered from any of the following please tick the appropriate box.

	Pain in Head
	Soreness in Neck
	Shoulder Pain
	Shoulder Stiffness
	Arm Pain
	Tennis Elbow
	Loss of Arm Power
	Pins & Needles in Hand(s)
	Pain between shoulders
	Tension between shoulders
	Pain in Ribs or Chest
	Low Back Pain
	Low Back Weakness
	Low Back Stiffness
	Buttock Pain
	Leg Pain or Cramps
	Pins & Needles of Leg(s)
	Knee Trouble
	Ankle Trouble
	Pins & Needles of Feet
	Jaw pain

	Headaches
	Migraines
	Dizziness
	Loss of Smell
	Sinus Trouble
	Hay Fever & Allergies
	Hearing Disturbances
	Recurrent Colds or Flu
	Recurrent Sore Throats
	Asthma
	Nausea
	Sleeping Problems
	Chest Pain
	Abdominal Pain
	Indigestion or Reflux
	Bloating
	Constipation or Diarrhoea
	Bed Wetting
	Irregular or painful periods
	Low Fertility
	Recurrent Cough
	Eye pain /Vision Disruption

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What are your current symptoms and their location_____
_____
_____
Original onset date: _____ Recent onset date: _____

How often do you have these symptoms? _____

What do you believe caused your condition? _____
_____

What previous treatment have you received for this condition, by whom and what were the results of that treatment? _____
_____
_____

Are you taking any medications, if so what are they for? _____
_____
_____

What accidents, significant falls or surgery have you had? _____
_____
_____

What is your preferred sleeping position? _____

For Women Only:

Is there any possibility that you might be pregnant? Yes ☐ No ☐

Please select topic that interest you and we'll send you occasional articles that will help you Get Well and Stay Well:

- ☐ Backaches & Sciatica
- ☐ Headaches & Neck Pain
- ☐ Wellness Topics
- ☐ Diet & Nutrition
- ☐ Exercise & Fitness
- ☐ Women's Health Issues
- ☐ Children's Health Issues
- ☐ Stress Management

Chiropractic care is recognised as being extremely safe and an effective method of care. As with all health care procedures it is acknowledged that there are risks. I hereby offer my consent to the proposed chiropractic care by the Chiropractors' of this clinic. I understand that I can withdraw consent at any time.

Patient's Signature: _____ Print Name Here: _____

Chiropractor's Signature: _____ Date: _____