WELCOME TO HEALTHY HAPPY CHIROPRACTIC

TODAY'S DATE: ____ / ____ / 2026

NAME: _____ **DOB:** ____ / ____ / _____

PREFERRED NAME: *(if different)* _____ **PHONE:** _____

ADDRESS: _____ **SUBURB:** _____ **POSTCODE:** _____

E-MAIL: _____@_____ *EMERGENCY CONTACT:* _____

THEIR PHONE: _____ *RELATIONSHIP TO YOU:* ☐ Partner ☐ Parent ☐ Child ☐ Sibling ☐ Carer ☐ Friend

RELATIONSHIP STATUS: ☐ SINGLE ☐ DE-FACTO/PARTNER ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ N/A – I'M A CHILD/TEEN

PARTNER'S NAME: _____ ARE YOU **CURRENTLY** (OR TRYING TO BECOME) **PREGNANT?** Y ☐ N ☐

DO YOU HAVE KIDS? 0 1 2 3 4 More THEY ARE: □ DEPENDANT < SCHOOL □ DEPENDANT – AT SCHOOL □ ADULT

WORK: □ BUSINESS OWNER □ PAID EMPLOYMENT □ HOME DUTIES □ PENSION □ STUDENT □ UNEMPLOYED □ VOLUNTEER □ RETIRED

OCCUPATION: _____

WHO CAN WE THANK FOR RECOMMENDING US TO YOU? _____

OR - I FOUND YOU THROUGH: □ GOOGLE □ SOCIAL MEDIA □ OUR WEBSITE □ SIGNAGE / WALK-DRIVE PAST □ SPECIAL OFFER

DO YOU HAVE A CURRENT **PRIMARY HEALTH PROFESSIONAL** OR **GP** ☐ N ☐ Y ***If YES…*** *DR or CLINIC NAME:* _____

HAVE YOU HAD PAST CHIROPRACTIC CARE? ☐ N ☐ Y ***If YES…*** *DR or CLINIC NAME:* _____

LAST VISIT: ☐ DAYS/WEEKS AGO ☐ < 6 MTHS ☐ > 6 MTHS ☐ <12 MTHS ☐ 1-3 YRS ☐ 3-5 YRS □ 5+ YRS

Your results? □ Excellent □ Satisfactory □ Okay/Fair □ Did Not Help □ Worsened

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WE STRIVE TO HELP PEOPLE IN 2 MAIN WAYS – WHAT DO YOU NEED FROM US RIGHT NOW?

☐ **STRUCTURAL ASSESSMENT | NERVOUS SYSTEM FUNCTIONAL ASSESSMENT | WELLNESS EVALUATION**

I have no specific health concerns. I'm here for help to live a more vibrant, healthy, productive life.

☐ **CURRENT HEALTH CONCERNS / CHALLENGES / SYMPTOMS** OR **DYSFUNCTION**

I'm seeking your professional opinion about their causes and the best ways to achieve lasting healing

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PLEASE OUTLINE BASIC DETAIL ABOUT HEALTH CONCERNS, SYMPTOMS OR DYSFUNCTION YOU MAY HAVE:

WHY ARE YOU HERE? *Please describe in brief what has brought you in to see us (ie. 'Back Pain')*

_____ **Does this cause DISCOMFORT or PAIN?**

_____ □ No □ Yes □ Sometimes

PLEASE TICK **ANY WORDS THAT DESCRIBE WHAT THESE SYMPTOMS FEEL LIKE:**

☐ SHARP ☐ DULL ☐ ACHING ☐ STABBING ☐ SHOOTING ☐ THROBBING ☐ CRAMPING ☐ STIFF ☐ SWOLLEN ☐ NUMB

☐ COLD ☐ HOT/BURNING ☐ VAGUE ☐ PINS & NEEDLES or TINGLING ☐ *Unsure / Can't describe*

ARE THESE SYMPTOMS: ☐ CONSTANT (Ongoing) ☐ INTERMITTENT ** (Come & Go) ☐ OCCASIONAL (Rare)

***If intermittent** they occur how often?* □ Daily □ Every Few days □ 1x/Wk □ Every 2 Wks □ 1x/Mth □ Few Mths □ Few x/Yr

THESE SYMPTOMS COME ON:

☐ AT A SPECIFIC TIME OF DAY ☐ WITH MOVEMENT ☐ IN SPECIFIC POSITION or POSTURE ☐ *No obvious pattern*

HOW LONG HAVE THESE SYMPTOMS BEEN AFFECTING YOU? ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

What **AGGRAVATES** or makes these symptoms worse? ☐ **NOTHING / UNSURE** or: _____

DO YOU FEEL THESE SYMPTOMS ARE: ☐ GETTING BETTER ☐ STAYING THE SAME ☐ GETTING WORSE

SEEN ANY OTHER HEALTH PROFESSIONALS FOR THIS? ☐ **NO** ☐ GP ☐ CHIRO ☐ PHYSIO ☐ OSTEO ☐ MASSAGE ☐ ACUPUNCTURE

PLEASE LIST ANY SIGNIFICANT **ILLNESSES** OR **SURGERIES** *(List year or how long ago…if you can):* □ **NONE**

_____

_____

PLEASE LIST ANY **MEDICATIONS YOU ARE TAKING** (*or have used in the* LAST 6 MONTHS): □ **NONE**

If you can – note the drug name or type (i.e. reason it has been prescribed) and dosage if you know (i.e. 10mg 2x/day))

☐ BLOOD PRESSURE ☐ BLOOD THINNER ☐ DIABETES ☐ CHOLESTEROL ☐ ANXIETY/DEPRESSION ☐ ANTIBIOTIC _____

_____

WOULD YOU DESCRIBE YOUR **USE OF OVER-THE-COUNTER PAIN MEDICATIONS** AS:

☐ **NEVER** ☐ UNUSUAL / VERY RARE ☐ OCCASIONAL SYMPTOMATIC USE ONLY ☐ REGULAR (DAILY or WEEKLY)

(Female) ARE YOU currently taking **BIRTH CONTROL MEDICATION** (or have history of long-term past use) □ YES □ **NO**

PLEASE LIST ANY **SUPPLEMENTS YOU ARE TAKING** (OR HAVE USED IN THE LAST 6 MONTHS): □ **NONE**

☐ OMEGA-3 ☐ VITAMIN D ☐ PROBIOTICS ☐ PREBIOTICS ☐ VITAMIN C ☐ VITAMIN B ☐ IRON ☐ VITAMIN K2

☐ ORAL MAGNESIUM ☐ VITAMIN E ☐ CHONDROITIN/GLUCOSAMINE ☐ CREATINE/PROTEIN ☐ MULTIVITAMIN

☐ MULTI-MINERAL 'GREEN' DRINK ☐ PREGNANCY SUPPS ☐ ELECTROLYTES ☐ OTHER: _____

HAVE YOU **BEEN IN/HAD** ANY TYPE OF **MOTOR VEHICLE / MOTOR BIKE ACCIDENT** (EVEN IF MINOR)?

□ **NEVER** ☐ DAYS/WEEKS AGO ☐ < 6 MTHS ☐ > 6 MTHS ☐ <12 MTHS ☐ 1-3 YRS ☐ 3-5 YRS ☐ 5-10 YRS ☐ 10+ YRS

DO YOU HAVE **CURRENT** or **PAST HISTORY** of any **DIAGNOSED ILLNESSES?** (TICK below):

☐ ADDICTIONS ☐ AIDS ☐ ARTHRITIS ☐ AUTO-IMMUNE DISEASE ☐ ANXIETY ☐ BIPOLAR ☐ (HISTORY OF) CANCER

☐ DEPRESSION ☐ DIABETES ☐ EPILEPSY ☐ EATING DISORDER ☐ HEART DISEASE ☐ HORMONE IMBALANCE

☐ NERVOUS BREAKDOWN ☐ OSTEOPOROSIS ☐ SCOLIOSIS ☐ SLEEP APNOEA ☐ THYROID DYSFUNCTION

☐ OTHER: _____

DO YOU **SLEEP WELL?** *(Get to Sleep / Stay Asleep / Wake Refreshed)*			☐ NO	☐ YES	
DO YOU **THINK YOU MOVE YOUR BODY / EXERCISE ENOUGH?**			☐ NO	☐ YES	
DO YOU **SMOKE?**			☐ NO	☐ YES	☐ PAST
DO YOU **DRINK ALCOHOL?**	☐ NEVER	☐ OCCASIONALLY	☐ 1-2/WEEK	☐ 3-5x/WEEK	☐ DAILY
DO YOU **SEE A DENTIST REGULARLY?**			☐ NO	☐ YES 6 MTHS	☐ YES 12 MTHS
DO YOU **THINK YOUR EATING HABITS AND MENU:**			☐ ARE GOOD	☐ NEED IMPROVEMENT	

Is there **any other information you wish to share** which you may feel is relevant to your visit with us today?

_____

_____

SIGNATURE: _____ DATE: ____ / _____ / 2026