CONFIDENTIAL **PATIENT** **HEALTH** **R** DATE

PERSONAL HISTORY

Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Name: _____

Home ☎: _____

Mobile ☎: _____

Business ☎: _____

E-mail: _____

Address: _____

_____

_____

Birth Date: _____ Age: _____

Marital Status: _____

Ages of Children: _____

Current Occupation: _____

How did you hear about Get Back Health Chiropractic Clinic? _____

Name of Doctor & contact details: _____

_____

I consent to receiving SMS apppointment reminders and and educational e mails as part of my health programme. Y

N

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

When did this condition begin? _____ Has this condition occurred before? Yes ☐ No

Is the condition: Job Related ☐ Car Accident ☐ Home Injury ☐ Fall ☐ Other ☐ _____

_____

Type of treatment: _____ Results: _____

Please list any medication and/or vitamins/supplements you are taking?: Nerve Pills ☐ Pain Killers ☐

Muscle relaxants ☐ Blood Pressure Medicine ☐ Insulin ☐ Other _____

Please list any conditions under current medical care: _____

Do You Intake: Cigarettes ☐ Per Day? _____ Alcohol ☐ Units per Week? _____ Caffeine ☐ ____

PAST HEALTH HISTORY

Major Surgery/Operations:

Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Knee Surgery ☐

Pelvic Surgery ☐ Other ☐ _____

Please list any past accidents/falls_____

Please list any fractures/ dislocations_____

Please list any visits to hospital (other than above): _____

Date of last physical examination by doctor: _____

Have you previously had Chiropractic care: Yes ☐ No ☐

Doctor's name & approximate date of last visit: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISEASES?:

☐ Pneumonia ☐ Mumps ☐ Influenza ☐ Thyroid ☐ Eczema **DETAILS:**_____

☐ Rheumatic Fever ☐ Small Pox ☐ Pleurisy ☐ Asthma ☐ Measles _____

☐ Polio ☐ Chicken Pox ☐ Arthritis ☐ Anaemia ☐ Heart Disease _____

☐ Tuberculosis ☐ Diabetes ☐ Epilepsy ☐ Cancer ☐ Whooping Cough _____

PSORIASIS ms OSTEOPORSIS

Have you been tested HIV positive? ☐ Yes ☐ No

HAVE YOU BEEN DIAGNOSED WITH AN INFECTIOUS DISEASE Y N

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain or Stiffness
- ☐ Leg pain
- ☐ Walking Problems
- ☐ Difficulty Chewing or Clicking Jaw
- ☐ General stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion or Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold or Tingling Extremities
- ☐ Stress

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Hayfever

GASTRO-INTESTINAL

- ☐ Poor or Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Haemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Problems
- ☐ Abdominal Cramps
- ☐ Gas or Bloating After Meals
- ☐ Heartburn
- ☐ Black or Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful or Excessive Urination
- ☐ Discoloured Urine
- ☐ Urinary Tract Infection

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems or Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EARS-NOSE-THROAT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat or Throat Problems
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Sinus Problems

MALES

- ☐ Prostate/ or Sexual Dysfunction

FEMALES

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Breast Pain/ or Lumps

What was the date of your last period? _____

Are you pregnant?

Yes ☐ No ☐ Not Sure ☐

Please mark areas of discomfort or pain on the diagram below.