



CONFIDENTIAL PATIENT INFORMATION

Full name:		Date:	
Address:			
Street	Suburb	State	P/Code
Home phone:		Work phone:	
Mobile:		Email address:	
Date of birth:		Age:	
No. Of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital status:		Occupation:	
Do you have: HCC <input type="checkbox"/> Pension Card <input type="checkbox"/>		Private Health Insurance <input type="checkbox"/>	

Emergency Contact Name & Phone No: _____

Whom may we thank for referring you? _____

If you have no symptoms or complaints and are here for Chiropractic Wellbeing Services, please skip to the "General Health History".

Health Concerns- Why are you here today?

Please list your health concerns/symptoms according to their severity	Rate of severity 1 = mild 10 = terrible	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?
1.				
2.				

Who else have you seen for this condition? _____

Since the problem started is it: About the same? Getting better? Getting worse?

What aggravates your condition? _____

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily Routine <input type="checkbox"/>	Sports/Exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History *Often accumulation of life's stress can lead to health problems and influence your ability to heal. Please pay close attention to this, as it will help us help you!*

Have you had any surgery?

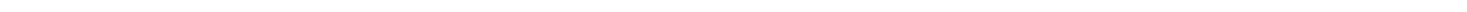
1. Type:	When?
2. Type:	When?

Have you had any accidents and/or injuries: car, work-related, or other? (Especially those related to your present problems).

Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Current Medicines and Supplements

Please list any medications/drugs, nutritional supplements, vitamins, or homeopathics you have taken regularly in the past 6 months and why: (prescription and non-prescription)



Diet Please indicate which of these are part of your regular diet:

Alcohol	Coffee	Artificial Sweetener	Refined Sugar
Tobacco	Soft Drink	Weight Control Diet	Protein Supplements

Past Health History Please mark the following conditions you may have had:

<input type="checkbox"/> Allergy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ulcers

Other (please explain) _____

Stressors Because accumulation of stress affects our health and ability to heal please list your top two stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____

Please grade your present levels of stress using scale: High, Medium, Low

At work:	At home:	At play:
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Using the scale of: Excellent, Good, Average or Poor

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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Is there anything else which hasn't been covered which you feel is important? If so, what? _____

Has your problem/s forced you to give anything up or modify your life in any way? If so, what/how? _____

What do you hope to achieve from your time here? _____

I hereby consent to the performance of a complete chiropractic examination and treatment by any registered chiropractor engaged by Westernport Innate Chiropractic. I have been informed of all the risks associated with the recommended treatment in terms that I have understood and have also been given the opportunity to ask questions. I understand that results are not guaranteed and that the chiropractor will always act in my best interests based on the facts known at that time. I acknowledge that any fee for services rendered are due at the time of the service and cannot be deferred to a later date. I understand the above and consent to chiropractic treatment for my present condition and any future condition(s). I also understand that I can withdraw my consent at any time.

Print Patient Name: _____

Signature: _____ Date: _____