



Chiropractic Registration and History

Personal information

Full name: _____ Date of birth: _____
(as appears on Medicare Card)

Residential address: _____

Suburb _____ State: _____ Postcode: _____

Phone/Mobile: _____ Email Address: _____

Occupation: _____ Marital status: _____ No. of dependent children: _____

Emergency contact Name: _____ Relationship: _____ PH: _____

Health Insurance: **Y** or **N** Name of Health Fund: _____

How did you find us? _____

Reason for visit

Reason for visit: _____

When did your symptoms first appear? _____

Is your condition getting progressively worse? _____ Severity of your condition (0 least – 10 severe): _____

Type of pain: Sharp Dull Throbbing Burning
(please circle) Numbness Cramping Other: _____

Frequency of pain: Constant Irregular
(please circle)

Does it interfere with: Work Sleep Daily Routine Recreation
(please circle)

Activities that are most painful: _____

Activities that the pain stops you from doing: _____

Please mark on the pictures where you have pain, numbness or tingling.



Drs. Notes

Health history

Have you received other types of care for your condition? _____

Have you received any previous chiropractic care: No / Yes

Chiropractor's name: _____ Address: _____

GP's name: _____ Practice name: _____

Date of last spinal examination (x-ray, MRI, CT or bone scan): _____

Surgeries/operations: _____

Please tick the following conditions you currently have:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Troubles	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Constipation
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Disc Problem	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Stomach Issues	<input type="checkbox"/> Thyroid Problems

Other: _____

Please tick the following conditions your parents may have had or currently have:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Troubles
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Disc Problem	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Migraines	<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Stomach Issues

Medications/Vitamins/Supplements: Please list any of the following you are currently taking:

Medications: _____

Vitamins: _____

Supplements: _____

For women only:

Are you pregnant? No / Not sure / Yes, due date: _____

Stressors

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

1. Physical stress (falls, accidents, work postures, sports etc).

- _____
- _____
- _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc).

- _____
- _____
- _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc).

- _____
- _____
- _____

On a scale of 1-10 (1 being very low and 10 being extreme) please grade your current levels of stress. Including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10 (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Authority

I hereby authorise the Chiropractic Doctor to perform any necessary diagnostic procedures, to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature: _____

Date: _____

I give permission for my name to be added to the Welcome and health news emailing list. Yes No