The Joint

Chiropractically….Cleveland

Suite 7 / 120 Bloomfield street Cleveland Qld 4163
P 07 3821 3103
E thejointcleveland@gmail.com

Chiropractic Registration and History

Name:_____Today's Date:_____

Residential Address:_____

State:_____Suburb_____Postcode:_____

Home Phone:_____Mobile:_____Email Address:_____

Date of Birth:_____Age:_____Occupation:_____Marital Status:_____

Partner's Name:_____Ages of any children:_____

Emergency contact Name:_____Relationship:_____PH:_____

Health Insurance: Yes or No Name of Health Fund:_____

Whom may we thank for referring you here_____

Patient Condition

NB: Spinal misalignments (known as subluxations) that have been affecting the spine for long periods of time may be associated with damaging spinal patterns which lead to back pain and compromised health. To help us locate and correct these patterns, please complete the section below.

Reason for visit:_____

When did your symptoms first appear?_____

Is your condition getting progressively worse?_____

Rate the severity of your condition (0 least – 10 severe)_____

Type of pain: *Please circle* **Sharp** **Dull** **Throbbing** **Burning**
Numbness **Cramping** **Other**

Frequency of pain: *Please circle* **Constant** **Irregular**

Does it interfere with: *Please Circle* **Work** **Sleep** **Daily Routine** **Recreation**

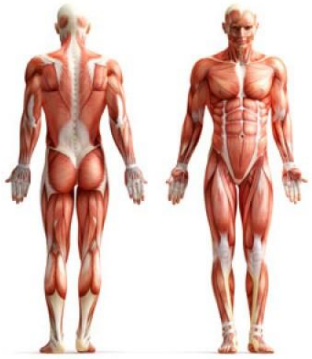
Activities that are most painful:_____

_____

Activities that the pain stops you from doing:_____

_____

Please put an X on the picture where you have pain, numbness or tingling



Health History

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

_____

Have you received any previous chiropractic care: **Y** **N**

Chiropractors Name _____Address:_____

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

Surgeries/Ops:_____

_____

Please tick the following conditions you and your family members may have had or currently have:

You	**Parents**	**Siblings**	**Spouse**	**Children**
Arthritis□	Arthritis□	Arthritis□	Arthritis□	Arthritis□
Asthma□	Asthma□	Asthma□	Asthma□	Asthma□
Back Trouble□	Back Trouble□	Back Trouble□	Back Trouble□	Back trouble□
Bursitis□	Bursitis□	Bursitis□	Bursitis□	Bursitis□
Cancer□	Cancer□	Cancer□	Cancer□	Cancer□
Constipation	Constipation□	Constipation□	Constipation□	Constipation□
Diabetes□	Diabetes□	Diabetes□	Diabetes□	Diabetes□
Disc Problem□	Disc Problem□	Disc Problem□	Disc Problem□	Disc Problem□
Emphysema□	Emphysema□	Emphysema□	Emphysema□	Emphysema□
Epilepsy□	Epilepsy□	Epilepsy□	Epilepsy□	Epilepsy□
Headaches□	Headaches□	Headaches□	Headaches□	Headaches□
Heart Trouble□	Heart Trouble□	Heart Trouble□	Heart Trouble□	Heart Trouble□
Liver Trouble□	Liver Trouble□	Liver Trouble□	Liver Trouble□	Liver Trouble□
Kidney Trouble□	Kidney Trouble□	Kidney Trouble□	Kidney Trouble□	Kidney Trouble□
Insomnia□	Insomnia□	Insomnia□	Insomnia□	Insomnia□
High Blood pressure□	High Blood pressure□	High Blood pressure□	High Blood pressure□	
Migraine□	Migraine□	Migraine□	Migraine□	Migraine□
Neuritis□	Neuritis□	Neuritis□	Neuritis□	Neuritis□
Neuralgia□	Neuralgia□	Neuralgia□	Neuralgia□	Neuralgia□
Anxiety□	Anxiety□	Anxiety□	Anxiety□	Anxiety□
Pinched Nerve□	Pinched Nerve□	Pinched Nerve□	Pinched Nerve□	Pinched Nerve□
Scoliosis□	Scoliosis□	Scoliosis□	Scoliosis□	Scoliosis□
Sinus Trouble□	Sinus Trouble□	Sinus Trouble□	Sinus Trouble□	Sinus Trouble□
Stomach Issues□	Stomach Issues□	Stomach Issues□	Stomach Issues□	Stomach Issues□

Medications/Vitamins/Supplements

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

For women only
Are you pregnant? Yes/no/not sure Due Date:_____
List any childbirth complications and/or interventions:_____

Please tick if we can help you with any of the following:

Happier moods □	Fatigue □	Muscle Strength □
Bowel function □	Coping with stress □	Muscle tension □
Digestion □	Depression □	Quality of sleep □
Quality of life □	Stiffness/arthritis □	

Trauma History

Spinal misalignments (subluxations) may result from accidents, injuries and falls no matter how innocuous they may seem, from as far back as our birth, including the birth process itself. Please recall your 5 most serious traumas and list them below.

Description	Date
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Please list any **current** sports/recreational activities:

_____

Please list any **past** sports/recreational activities:

_____

Are there any other kinds of stress: Mental, Physical, Chemical or Spiritual that you may not have mentioned? _____

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

Patient Signature:_____ Date:_____