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: _____ 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? _____

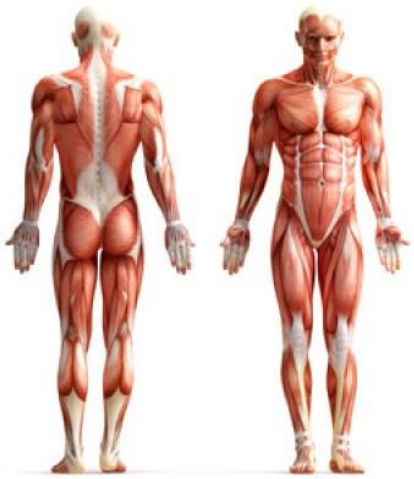
Is your condition getting progressively worse?_____ Severity of your condition (0 least – 10 severe): _____

Type of pain: (*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 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: _____

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

Surgeries/operations: _____

_____

Please tick the following conditions you currently have:

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

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

□ Arthritis	□ Anxiety	□ Asthma	□ Back Troubles
□ Bursitis	□ Cancer	□ Constipation	□ Diabetes
□ Disc Problem	□ Emphysema	□ Epilepsy	□ Headaches
□ Heart Trouble	□ High Blood Pressure	□ Insomnia	□ Kidney Trouble
□ Liver Trouble	□ Migraines	□ Neuralgia	□ Neuritis
□ Pinched Nerve	□ Scoliosis	□ Sinus Trouble	□ 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:

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:

How do you grade your physical health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your emotional/mental health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

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:_____