DATE:_____

PATIENT HEALTH QUESTIONNAIRE

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. Thank you

NAME: _____ PHONE: (H) _____

ADDRESS: _____ (W) _____

SUBURB: _____ STATE: _____ PCODE: _____ (M) _____

DATE OF BIRTH:_____ **MARITAL STATUS: S** ☐ **M** ☐ **NO. OF CHILDREN:**_____

OCCUPATION:_____ EMAIL: _____

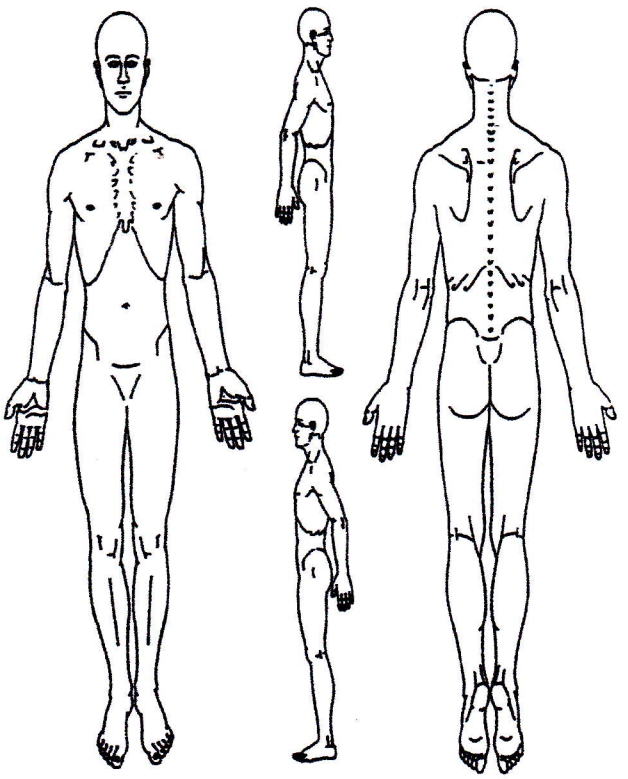
REFERRED BY: PATIENT: ☐ _____ **DOCTOR** ☐ **WEBSITE** ☐ **GOOGLE** ☐ **DROVE BY** ☐

REASON FOR THIS VISIT: describe major symptoms & complaints_____

_____

_____

AREAS OF SYMPTOMS (indicate by marking)



IS THE REASON FOR YOUR VISIT TO:

Alleviate your symptoms ☐

Correct the cause of your symptoms ☐

WHEN DID YOU FIRST NOTICE THESE SYMPTOMS:_____

WHOM HAVE YOU CONSULTED FOR THIS PROBLEM:_____

DID YOU HAVE A.

X-RAY ☐ **C/T SCAN** ☐ **MRI** ☐ **ULTRA SOUND** ☐

WHAT TREATMENT HAVE YOU RECEIVED?

_____

HAS THIS HAPPENED BEFORE? YES ☐ NO ☐

If so, when?_____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE:

Where?_____When?_____

DATE OF LAST PHYSICAL EXAMINATION: _____

MEDICATION YOU NOW TAKE:

PAIN KILLERS ☐ **SEDATIVES** ☐ **BIRTH CONTROL** ☐ **NERVE PILLS** ☐ **INSULIN** ☐

MUSCLE RELAXERS ☐ **ANTI INFLAMATORIES** ☐ **BLOOD PRESSURE** ☐ **OTHER**_____

HAVE YOU BEEN IN A ROAD ACCIDENT? CAR ☐ **TRUCK** ☐ **MOTORBIKE** ☐ **BICYCLE** ☐ **PEDESTRIAN** ☐ **DATE:** _____

HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT? When: _____