Carter Family Chiropractic Centre

Leeton
Griffith
Narrandera

Dr Mark Carter (Chiropractor)
Dr Rhyan Carter (Chiropractor)
Joanne Carter (Office Manager)
Donna Tuckett (Chiropractic Assistant)

PATIENT INFORMATION

Date: _____

Surname: _____Given Name: _____ DOB: _____ /____ /_____

Preferred Name: _____ Sex: M / F Age: _____

Address: _____ Town: _____ P/Code: _____

H.Phone # _____ W.Phone # _____ Mobile #_____

Marital Status: S M DF W D Partners Name: _____ #Children_____

Occupation: _____ Email: _____

Who recommended you to us? _____ Health Insurance? Y / N

Emergency Contact Person(s) _____Contact # _____

CURRENT HEALTH HISTORY

Have you ever seen a Chiropractic before? Y / N **What For**? Pain / Spinal Supportive Care / Subluxation Correction.

When? _____**Outcome:** _____

Medical Doctors Name: _____ Phone: _____

What is your Primary Complaint? _____

Does it travel anywhere else? Explain. _____

How long have you had this problem? _____ Has it been present in the past? i.e. reoccurring Y / N

Was there an incident that caused this? Y / N Describe: _____

Are your symptoms getting: ☐ - Worse ☐ - Better ☐ - the Same ☐ - Comes & Goes?

What aggravates your condition? _____

What relieves your condition? _____

When is the condition worse? E.g. Morning/Afternoon/with movement? _____

Does it interfere with: ☐ - Work ☐ - Sleep ☐ - Daily Routine?

Is it aggravated by: ☐ - Cough ☐ - Sneeze ☐ - Having a Bowel Motion

Does the pain wake you up at night? Y / N

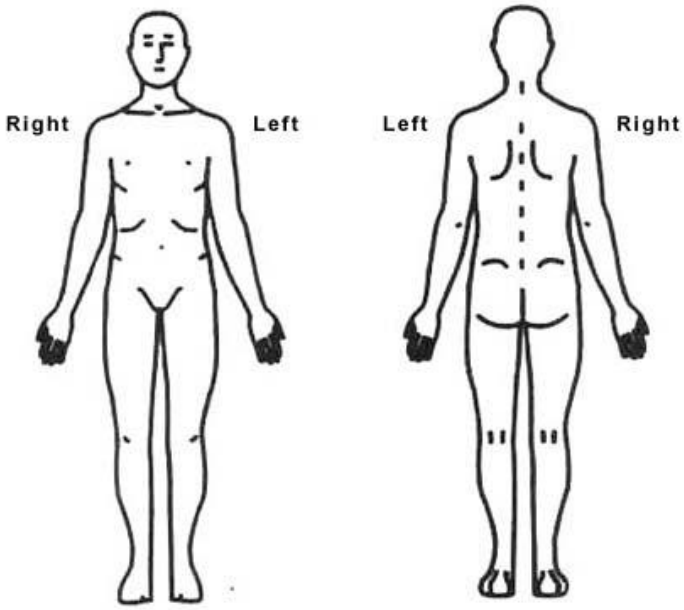
Have you had previous treatment for this problem? Y / N Where? _____When? _____

What was the diagnosis? _____

What treatment was performed? _____Did it help? _____

Using the scale below, mark the intensity of the pain/discomfort you're experiencing.

(No Pain) > 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 < (*Severe Pain)*



Please illustrate where your problem(s) are located.

Use these symbols:

++++ Dull/Ache	×××× Sharp/Stabbing
oooo Burning	//// Cramping
1111 Stiffness	2222 Numbness
3333 Throbbing	#### Pins & Needles

Work history: Present Occupation / Duties _____

Previous Occupation / Duties _____

Do You Smoke? Y / N How many a day? _____ Have you ever smoked? Y / N When did you stop? _____

If female, is there ANY possibility you are pregnant? Y / N

Current Medications: _____

Please list any car/bike accidents, injuries/broken bones/surgery or hospitalisations: _____

Please detail any medical conditions you have been diagnosed with:

_____

_____

Are you *currently* or have you *in the past* ever suffered from: (*Tick)*

☐ - Night Pain ☐ - Night Sweats / Fever ☐ - Nausea / Vomiting ☐ - Dizziness / Loss of Balance

☐ - Unexplained weight loss ☐ - Numbness (Torso, Head, Limbs) ☐ - Double Vision

☐ - Nystagmus (Fast, uncontrollable movements of the eye(s) ☐ – Difficulty speaking/swallowing/walking

☐ - Fatigue/body weakness

☐ - Unexplained changes to bowel/bladder function? Explain _____

☐ - Stress ☐ - Anxiety ☐ - Depression ☐ - Worries

Family history of any illness or condition(s) Eg Cancer / Stroke / Heart Disease / Diabetes etc _____

_____

If you could improve anything about your health, what would be your goals?

1._____ 2._____ 3._____

What are your sports / hobbies? _____

How would you rate your general wellbeing ___ / 10

Patient Name: _____ Signature: _____

Practitioner Name: _____ Signature: _____

Office Use Only: Patient Identification Number: _____