# CONFIDENTIAL PATIENT INFORMATION

Floreat Chiropractic
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Floreat Chiropractic
Feel & Move Better

## Personal Information

Full name: _____
Address: _____
Occupation: _____
Date of Birth: _____ Age: _____
No. of Children: _____ Pregnant? Y N Due Date:
Spouse/Guardian name: _____
Who may we thank for referring you?_____

Phone (H): _____
Phone (W): _____
Phone (M): _____
Email: _____
Best time/place to contact you:
_____
_____

## Health Concerns

### What brings you to us today?

| What are your health concerns? | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | Percentage of the time pain is present |
|---|---|---|---|---|
| | | | | |
| | | | | |

Since the problem started is it: About the same? Getting Better? Getting worse?

Please score your pain 1 (less) 10 (more): 1_____10

What have you done for this condition? Was it of benefit?

_____
_____
_____

I do / do not have a family history of this or similar symptoms (Please explain):

_____
_____
_____

What activities aggravate your condition?

_____
_____

How are these conditions affecting your life? (i.e. Sports, walk, pick up children, lifting, working, running etc.)

_____
_____

Is this condition interfering with any of the following?
Work Sleep Daily Routine Sport/Exercise Other: _____
Have you had chiropractic care before? Y N Where _____ When _____
How was your experience? Excellent Good Fair Poor Worse
Have you ever had a painful or unusual reaction to an adjustment or manipulation? Y N
If Yes, please describe what happened: _____

## General Health History

*Often, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

Have you had any hospitalisations or operations?

_____

Have you had any accidents and/or injuries auto, work-related, or other?

_____

Have you ever had x-rays taken? _____ Area of body: _____

When? _____ Where? _____

Do you wear orthotics or heel lifts? Y N

## Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

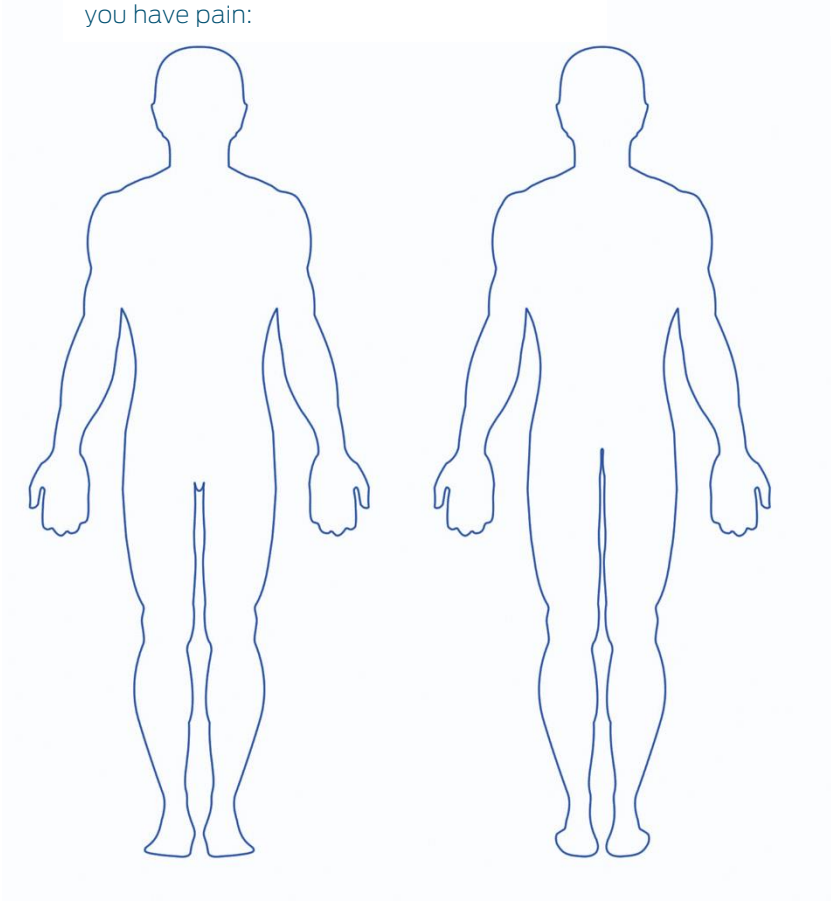
1. _____ Reason: _____ 2. _____ Reason: _____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

1. _____ Reason: _____ 2. _____ Reason: _____

## Physical Pain

Please mark the areas of your body where you have pain:



## Past Health History

*Please mark the following conditions you may have had or have now (- have had + have now):*

| | | | |
|---|---|---|---|
| Headache | | Arteriosclerosis | |
| Neck Pain | | Heart Disease | |
| Migraines | | Diabetes | |
| Mid Back Pain | | Low Blood Sugar | |
| Lower Back Pain | | Menstrual Cramps | |
| Arthritis | | Irregular Periods | |
| Pins/Needles | | Miscarriage | |
| Numbness | | Anemia | |
| Allergy | | Asthma | |
| Sinus Problems | | Pneumonia | |
| Cold Sores | | Emphysema | |
| Eczema | | Gout | |
| Thyroid Issues | | Cancer | |
| Ulcers | | Multiple Sclerosis | |
| Diarrhea | | Depression | |
| Constipation | | Alcoholism | |
| Heart Attack | | Nervousness | |
| Stroke | | Epilepsy | |
| High Blood Pressure | | Dizziness | |
| Low Blood Pressure | | Other | |

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. Print Name: _____Signature: _____Date: _____