MINDARIE KEYS CHIROPRACTIC & WELLNESS CENTRE

PERSONAL AND FAMILY HISTORY

Name: _____ Today's date: _____ Date of Birth: _____

Address: _____ Sex: ❑ F ❑ M Private Health Fund: _____

Suburb: _____ Postcode: _____ Are you or might you be pregnant? ❑ Yes ❑ No

Phone: _____ Occupation: _____

Emergency Contact name and number: _____ Spouse's Name: _____

_____ Age of children: _____

Email: _____ **Referred by:** _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have **NO** symptoms or complaints and you are here for wellness care, please tick here
❑ I wish to have Chiropractic Wellness Care & skip to the CURRENT SYMPTOMS section near the bottom of this form. Otherwise, please continue.

Present complaint (Reason for your visit today): _____

Pain or problem started how and when? _____

What activities make your condition/pain worse? _____

What activities make your condition/pain better? _____

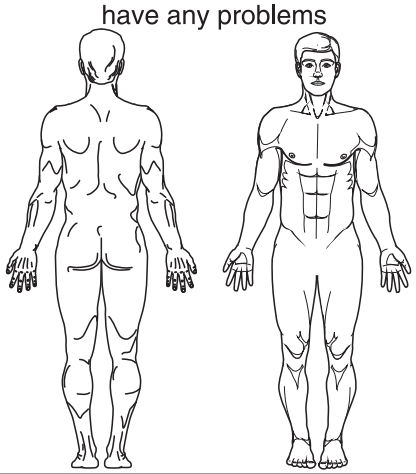
If you have pain, is it... ❑ sharp ❑ dull ❑ radiating ❑ constant
❑ mild ❑ moderate ❑ mod-severe ❑ severe
❑ intermittent

Since it began, is it... ❑ the same ❑ variable ❑ getting better ❑ getting worse

Does it interfere with.. ❑ work ❑ sleep ❑ walking
❑ sitting ❑ exercise ❑ other _____

Are there other doctors/treatments that you have tried for this problem?(Please tick)
❑ massage therapist ❑ physiotherapist
❑ acupuncturist ❑ medical doctor
❑ chiropractor ❑ other

Circle/mark the areas where you have any problems



FAMILY HEALTH PROFILE - Please mark if you have a family history of:

	Arthritis	Cancer	Diabetes	Heart Disease	High Blood Pressure	Strokes	Other _____
Your father's side	❑	❑	❑	❑	❑	❑	❑ _____
Your mother's side	❑	❑	❑	❑	❑	❑	❑ _____
Your children	❑	❑	❑	❑	❑	❑	❑ _____

MEDICAL INFO: Who is your medical doctor? _____
If you are taking medications, please list them.
MED: _____ For what? _____ For how long? _____
MED: _____ For what? _____ For how long? _____
MED: _____ For what? _____ For how long? _____

OTHER:
If you have had any surgeries, please list them.
Surgery/Purpose: _____ Date: _____
Surgery/Purpose: _____ Date: _____
Surgery/Purpose: _____ Date: _____

TRAUMA & INJURIES

Did you ever...

		If yes, please explain
Have any personal injury or accident?	Y / N	
Have recurrent childhood illness/sickness?	Y / N	
Experience other serious traumas/stress?	Y / N	
Have any mental or emotional disorders?	Y / N	
Suffer any concussions?	Y / N	

OTHER HEALTH HABITS

Do you...

Eat healthy foods regularly?	Y / N	Have high mental stress?	Y / N
Drink 8-10 cups of water per day?	Y / N	Have high physical stress?	Y / N
Exercise regularly?	Y / N	Have sleeping problems?	Y / N
Smoke?	Y / N	Sleeping position: side, stomach, back	
Take vitamins or supplements?	Y / N		

Have you been to a Chiropractor before? Y/N If yes, who have you seen? _____

If yes, for what? _____ When was your last adjustment? _____

CURRENT SYMPTOMS (even if they do not seem related to your current condition).

- ❑ headaches / migraines
- ❑ neck stiffness / pain
- ❑ shoulder stiffness / pain
- ❑ pins and needles in arms
- ❑ numbness in fingers
- ❑ back stiffness / pain
- ❑ pins and needles in legs
- ❑ numbness in feet / toes
- ❑ foot problems
- ❑ jaw / TMJ problems
- ❑ other _____
- ❑ dizziness / vertigo
- ❑ fatigue
- ❑ sleeping problems
- ❑ tension / stress
- ❑ nervousness / anxiety
- ❑ irritability / mood swings
- ❑ depression
- ❑ stomach upset
- ❑ heartburn / reflux
- ❑ ulcers
- ❑ sinus problems / allergies
- ❑ shortness of breath
- ❑ constipation / diarrhea
- ❑ problems urinating
- ❑ cold sweats
- ❑ hot flashes
- ❑ menopause
- ❑ PMS / menstrual cramps
- ❑ infertility / impotence
- ❑ cold hands / feet
- ❑ high blood pressure
- ❑ heart problems / stroke
- ❑ cancer
- ❑ diabetes
- ❑ recurring infection
- ❑ loss of smell / taste
- ❑ vision changes
- ❑ buzzing / ringing in ears
- ❑ loss of balance
- ❑ chest pains

RESULTS:

As a result of my chiropractic care, I would like to achieve: (tick all boxes that apply)

❑ Relief Care ❑ Corrective Care ❑ Wellness Care

PLEASE NOTE:

Payment on the day by Cash or Eftpos only.
A $50 missed appointment fee applies if less than 8 hours notice is given.
Declaration: I am responsible for full payment of my account after each treatment.

Signed: _____ Dated: _____

I understand this clinic functions on a pay as you go basis and I am financially obligated for any fees, with the understanding this clinic will gladly prepare forms and reports if necessary to enable me to regain reimbursement from insurance companies. (You can have/keep all x-rays upon request as long as your account is paid in full: however 24 hours notice is required)

Goals and Consent

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential.

Consent to Evaluation

I.....hereby grant permission to receive a chiropractic evaluation including history, examination and x-rays if required. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult/Guardian Signature Date

On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it is too late. Mindarie Keys Chiropractic & Wellness Centre will help to find and treat the cause of these effects. Chiropractic helps your entire body for a healthier life and spine.