Confidential Patient Case History

DEAR PATIENT: Please complete this questionnaire.
Your answers will help us to determine if Chiropractic can help you.

Title_____ First Name _____ Last Name _____ Preferred Name _____

Address_____ Suburb _____ Post Code _____

Phone: _____ Email: _____

D.O.B _____/_____/_____ Occupation_____ Children? How many? _____

How did you find out about us/who recommended you?

☐ Google ☐ Social Media ☐ Friend/Family - Name: _____ ☐ Other

Are you a concession card holder? Yes / No Concession no: _____ Expiry date ____ /____ /____

Do you have Private Health Cover? Yes / No Which fund? _____

Please tick if you have suffered from any of the following symptoms, whether past or present:

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches / migraines	☐	☐	Pain in ribs	☐	☐	Chronic cough / asthma
☐	☐	Pain in head	☐	☐	Low back pain / stiffness	☐	☐	Frequent nausea / vomiting
☐	☐	Soreness in neck	☐	☐	Low back weakness	☐	☐	Digestive malfunction
☐	☐	Dizziness	☐	☐	Hip pain / stiffness	☐	☐	Allergies
☐	☐	Shoulder pain	☐	☐	Buttock pain	☐	☐	Bed wetting
☐	☐	Arm pain	☐	☐	Leg pain / cramps	☐	☐	Urinary problems
☐	☐	Loss of arm power	☐	☐	Frequent pins & needles in legs or feet	☐	☐	Menstrual disorders
☐	☐	Shoulder pain / stiffness	☐	☐	Knee pain / stiffness	☐	☐	Loss of potency
☐	☐	Elbow pain	☐	☐	Ankle pain / stiffness	☐	☐	Other sexual disorders
☐	☐	Wrist or hand pain	☐	☐	Foot pain / stiffness	☐	☐	Chronic fatigue
☐	☐	Pins & needles in hands	☐	☐	Sleeping problems	☐	☐	Other……...
☐	☐	Loss of grip	☐	☐	Insomnia	……		
☐	☐	Mid back pain/tension	☐	☐	Sinus trouble	……		

Present Symptoms

What symptoms are you most concerned about?_____

Original onset date?_____ Recent onset date? _____

Caused by? _____

Previous treatment? _____ Result? _____

Have you had any ☐ X-rays ☐ CT Scans ☐ MRIs recently? Location?_____

Any family history of this problem? Yes / No Are you symptoms aggravated by, or related to, your work? Yes / No

What medications are you taking?_____

Have you seen a chiropractor before? Yes / No Is there any possibility that you might be pregnant? Yes / No

Do you sleep on your **Side / Back / Stomach**? Do you have a **Soft / Medium / Hard** mattress?

How many pillows do you use? _____

FINANCIAL POLICY*: We require payment at time of consultation.*

Cancellation Policy:

Tamar Chiropractic & Allied Health is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us by 5pm the business day prior to your scheduled appointment to notify us of any changes. Failure to do so incurs a fee equal to that of the booked appointment. Patient's

Signature……. Date……/……../……...

Do you authorise someone to make or change appointments on your behalf?

Nominated Person: …… Relationship: ……

Patient's Signature: ……

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