Confidential Patient Case History

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

Title……Name…… Today's Date……/……../…….

Address…… Suburb…… Post Code…….

Phone: Home……..…… Work…… Mobile……...……

Email: …… D.O.B……/……/……

Occupation…… Children? How many? ……..……

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

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
Do you sleep on your **Side / Back / Stomach**? Do you have a **Soft / Medium / Hard** mattress?
How many pillows do you use? ……
Is there any possibility that you might be pregnant? Yes / No

FINANCIAL POLICY: ***We would appreciate 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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