CONFIDENTIAL PATIENT INFORMATION

Full name:	**Date:**
Address: Street Suburb State P/Code	
Home phone:	**Work phone:**
Mobile:	**Email address:**
Date of birth:	**Age:**
No. Of children:	**Pregnant?** Yes ☐ No ☐
Marital status:	**Occupation:**
Do you have: HCC ☐ **Pension Card** ☐	**Private Health Insurance** ☐

Whom may we thank for referring you? _____

*If you have no symptoms or complaints and are here for Chiropractic Wellbeing Services, please skip to the **"General Health History"**.*

Health Concerns- Why are you here today?

Please list your health concerns/symptoms according to their severity	Rate of severity 1 = mild 10 = terrible	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?
1.				
2.				

Who else have you seen for this condition?_____

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

What aggravates your condition? _____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily Routine ☐	Sports/Exercise ☐	Other ☐ (please explain):

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

Have you had any surgery?

1. Type:	When?
2. Type:	When?

Have you had any accidents and/or injuries: car, work-related, or other? (Especially those related to your present problems).

Type:	When?	Hospitalized? Yes □ No □

Current Medicines and Supplements

Please list any medications/drugs, nutritional supplements, vitamins, or homeopathics you have taken regularly in the past 6 months and why: (prescription and non-prescription)

_____

Diet Please indicate which of these are part of your regular diet:

Alcohol	Coffee	Artificial Sweetener	Refined Sugar
Tobacco	Soft Drink	Weight Control Diet	Protein Supplements

Past Health History Please mark the following conditions you may have had:

☐ Allergy	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Eczema	☐ Gall Bladder Problems	☐ Gout	☐ High Blood Pressure	☐ Heart Attack
☐ Miscarriage	☐ Nervousness	☐ Pneumonia	☐ Stroke	☐ Thyroid Problems	☐ Ulcers

Other (please explain) _____

Stressors Because accumulation of stress affects our health and ability to heal please list your top two stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____

Please grade your present levels of stress using scale: High, Medium, Low

At work:	At home:	At play:

Using the scale of: Excellent, Good, Average or Poor

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

Is there anything else which hasn't been covered which you feel is important? If so, what? _____

_____

Has your problem/s forced you to give anything up or modify your life in any way? If so, what/how? _____

_____

What do you hope to achieve from your time here?_____

_____

I consent to a professional and complete chiropractic examination. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____

Signature: _____ Date: _____