chiropractic solutions
An individual approach to your health.

PATIENT INFORMATION

– CONFIDENTIAL

Date:

Please complete this document to the best of your ability. It will make your first appointment with your Chiropractor more comprehensive, efficient and beneficial.

Once you have completed, please return this document via email to: info@chirosolutions.com.au

PERSONAL DETAILS

TITLE: SURNAME: GIVEN NAMES:

DATE OF BIRTH: AGE: SEX:

MARITAL STATUS: NO. OF CHILDREN:

ADDRESS:

PHONE NUMBER: (Home) (Work): (Mobile):

EMAIL ADDRESS:

OCCUPATION: EMPLOYER:

How did you become aware of this clinic?

Who can we thank for referring you here?

Do you wish to receive FREE appointment reminders via SMS?

Occasionally this practice sends out newsletters, birthday cards or clinic promotions, are you happy to receive these?

Is this a Workers compensation, Vet Affairs or TAC claim? CLAIM No:

"I understand and agree that services rendered are charged directly to me and that I am personally responsible for payment, except where covered by Private Health Insurance. I also understand that any missed appointments, late cancellations and reschedules will incur a fee"

INITIALS OF PATIENT: DATE:

GENERAL PRACTIONER DETAILS

NAME OF PRACTITIONER: CLINIC NAME:

ADDRESS: PHONE:

Do we have your consent to communicate with your GP about your condition?

CHIEF COMPLAINT 1

Location of your symptoms?

How would you describe your symptoms?

If pain, how do you rate this pain out of 10? (10 being the worst pain ever, and 0 being no pain):

When did this problem begin?

What caused this problem?

Has it been getting better, same or getting worse?

What aggravates your symptoms?

What relieves your symptoms?

Have you had any TREATMENT for this problem before? (If so, please complete table below)

Date	Type of treatment (e.g. Chiro/physio/massage)	Practitioner's name	Diagnosis	Response to treatment

Have you had any IMAGING performed on this problem before? (eg X-rays, CT scan, MRI scan, Ultrasound)

Date	Type of imaging (eg. X-ray, MRI)	Results

Additional notes:

CHIEF COMPLAINT 2

Location of your symptoms?

How would you describe your symptoms?

If pain, how do you rate this pain out of 10? (10 being the worse pain ever and 0 being no pain):

When did this problem begin?

What caused this problem?

Has it been getting better, same or getting worse?

What aggravates your symptoms?

What relieves your symptoms?

Have you had any TREATMENT for this problem before? (If so, please complete table below)

Date	Type of treatment (e.g. Chiro/physio/massage)	Practitioner's name	Diagnosis	Response to treatment

Have you had any IMAGING performed on this problem before? (eg X-rays, CT scan, MRI scan, Ultrasound)

Date	Type of imaging (eg. X-ray, MRI)	Results

Additional notes:

CHIEF COMPLAINT 3

Location of your symptoms?

How would you describe your symptoms?

If pain, how do you rate this pain out of 10? (10 being the worse pain ever and 0 being no pain):

When did this problem begin?

What caused this problem?

Has it been getting better, same or getting worse?

What aggravates your symptoms?

What relieves your symptoms?

Have you had any TREATMENT for this problem before? (If so, please complete table below)

Date	Type of treatment (e.g. Chiro/physio/massage)	Practitioner's name	Diagnosis	Response to treatment

Have you had any IMAGING performed on this problem before? (eg X-rays, CT scan, MRI scan, Ultrasound)

Date	Type of imaging (eg. X-ray, MRI)	Results

Additional notes:

CHIEF COMPLAINT 4

Location of your symptoms?

How would you describe your symptoms?

If pain, how do you rate this pain out of 10? (10 being the worse pain ever and 0 being no pain):

When did this problem begin?

What caused this problem?

Has it been getting better, same or getting worse?

What aggravates your symptoms?

What relieves your symptoms?

Have you had any TREATMENT for this problem before? (If so, please complete table below)

Date	Type of treatment (e.g. Chiro/physio/massage)	Practitioner's name	Diagnosis	Response to treatment

Have you had any IMAGING performed on this problem before? (eg X-rays, CT scan, MRI scan, Ultrasound)

Date	Type of imaging (eg. X-ray, MRI)	Results

Additional notes:

OTHER IMPORTANT HEALTH CARE INFORMATION

Have you had any fractures?

Details of fractures:

Have you had any previous surgery?

Date	Surgery performed

Have you suffered any significant accidents or injuries?

Date	Type of accident eg Car accident, fall	Injury sustained

Are you currently a smoker? If no, have you ever smoked in the past?

Have you ever been diagnosed with cancer?

Details:

Were you born with any health problem?

Details:

Do you suffer from any allergies?

Details:

Please list any current **medications** you are taking (including contraceptive pill):

Medication name	Dosage

Please list any current **nutritional supplements** you are taking (i.e. vitamins, minerals, herbs):

Supplement name	**Dosage**

Additional notes:

Please list any **regular exercise and sport** that you participate in:

Type of exercise	**Frequency** eg. once per week, daily ect.

What is your expectation from your initial consultation?
What would you like to achieve with treatment?
How is your problem affecting your life?
What do you think can help you?

HEALTH STATUS SCREEN

It is very important for us to know about any other health problems you may have, or have had in the past, as these can all contribute to your current condition. Please mark with the letter "x" if you have suffered from any of the below PREVIOUSLY or CURRENTLY.

Prev	Current		Prev	Current	
		GENERAL SYMPTOMS			**MUSCLE AND JOINTS**
		Numbness, pain or tingling			Stiff neck
		Loss of consciousness			Backache
		Blackouts			Painful tailbone
		Headache			Hip pain
		Fever			Knee pain
		Sweats			Ankle pain
		Fainting			Foot trouble
		Dizziness			Shoulder pain
		Clumsiness			Arm/forearm pain
		Convulsions			Elbow pain
		Loss of sleep			Wrist pain
		Nervousness			Hand pain
		Unexplained weight loss			Swollen joints
					Arthritis
		CARDIOVASCULAR			Weakness or loss of strength
		High blood pressure			
		Pain over the heart or chest			**E.E.N.T**
		Angina			Asthma
		Hardening of the arteries			Earache
		Low blood pressure			Eye pain
		Bleeding disorder			Ringing, buzzing, noise in ears
		Varicose veins			Sinus infections
		Swelling of ankles			Hayfever
		Poor circulation			Failing vision (one/both eyes)

		Stroke			Crossed eyes
					Double vision
		RESPIRATORY			Deafness
		Chronic cough			Blurred vision
		Chest pain			Frequent colds
		Spitting up phlegm			Enlarged glands
		Spitting up blood			Slurred or other speech problems
		Difficulty breathing			Difficulty swallowing
		Tuberculosis			

HEALTH STATUS SCREEN continued

Prev	Current		Prev	Current	
		GASTROINTESTINAL			**GENITOURINARY**
		Indigestion			Bed-wetting
		Nausea			Kidney infection
		Ulcers			Frequent urination
		Constipation			Blood in urine
		Diarrhoea			Burning with urination
		Diabetes			Prostate trouble
		Excessive hunger			Trouble urinating
		Belching or gas			
		Vomiting (blood?)			**G.U FOR WOMEN**
		Pain over the stomach			Cramps or backache
		Hemorrhoids (piles)			Painful menstruation
		Jaundice			Irregular cycle
		Gall bladder problems			Hot flashes
		Intestinal worms			Excessive flow
		Poor appetite			Vaginal discharge
					Swollen breasts
		SKIN			Lumps in breast
		Eczema			
		Rashes, itching			
		Psoriasis			
		Bruise easily			
		Dryness			
		Boils			
		Hives (allergy)			
		Recent changes in a mole/freckle			
		Acne			

Other health problems: