Personal Details

CONFIDENTIAL

PLEASE USE A BLACK PEN ONLY AS OUR SCANNER WILL ONLY PICK UP BLACK PEN

NAME: Dr/Mr/Mrs/Ms____

ADDRESS: ____

_________________________________ POSTCODE: _______________________

PHONE HOME: _____________________ PHONE WORK: _____________________

MOBILE PHONE: ____________________ EMAIL: __________________________

BIRTHDATE: _______________________ OCCUPATION: _____________________

PARTNER'S NAME: __________________ NO. OF CHILDREN: ________________

What Health fund do you belong to? _______________________________________

Are you covered for chiropractic care (we need to know this as some health funds require specific item numbers)? ____

Is this related to a Workers Compensation [ ] or Third Party Claim [ ] ? [ ] No

Who is your regular doctor (General Practitioner)? ____________________________

We are grateful that our practice grows by referral. Who may we thank for referring you?

____

Have you ever seen a Chiropractor before?

Yes [ ]

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Major Complaint

What is your main problem? ____

____

When and how did it start? ____

Was there any of the following prior to or during the onset? (Please circle)

- Illness / infection
- Trauma
- Other significant event

Is your problem getting worse? Yes / No ______________________________

What relieves your symptoms? ______________________________

What makes your symptoms worse? ______________________________

____

Are your symptoms worse at night or any specific time of the day? ____________________

____

Do you have any pain traveling down your arms or legs? Yes / No If yes, describe __________

____

Does your current problem involve any of the following? If Yes, where?

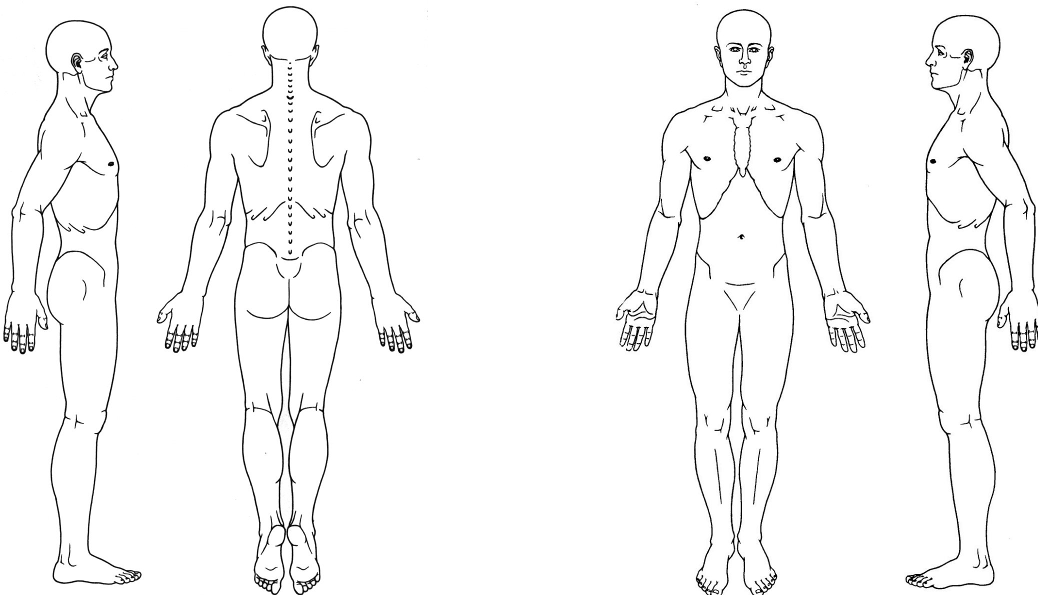
Tingling in either arm or leg	Yes / No	____________________
Numbness in either arm or leg	Yes / No	____________________
Weakness in either arm or leg	Yes / No	____________________
'Weird' sensations in either arm or leg	Yes / No	____________________

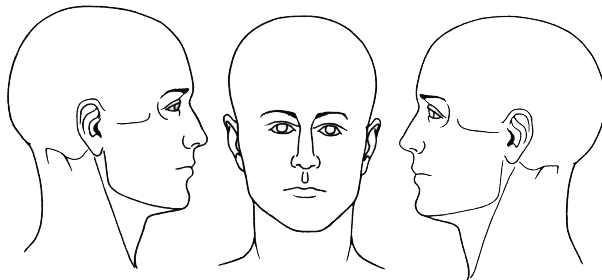
Have you had any other treatment for your current problem? Yes / No ____________________

____

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.





MT LAWLEY WELLNESS
on beaufort

Medical History & General Health

Please circle Yes/No where applicable:

Did you / Do you smoke? Yes / No ______________________

Did you / Do you drink alcohol? Yes / No ______________________

Did / Do you take recreational drugs? Yes / No ______________________

Do you think you have a healthy diet? Yes / No ______________________

Do you take vitamin supplements? Yes / No ______________________

Do you exercise regularly? Yes / No ______________________

Have you had any form of surgery? Yes / No ______________________

____

Are you currently taking *any* form of medication? Yes / No If yes list all of them ______________

____

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No

____

Have you had any broken bones? Yes / No If yes, which ones and how? ______________

____

Have you had any falls or sports injuries? Yes / No If yes, when and describe ______________

____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No

____

MT LAWLEY WELLNESS
on beaufort

Question	Answer	
Do you have allergy problems?	Yes / No	______________________
Do you have poor sleep?	Yes / No	______________________
Do you suffer from fatigue?	Yes / No	______________________
Did you / Do you have occupational stress?	Yes / No	______________________
Do you get pain in any of your joints?	Yes / No	______________________
If yes, is it worse in the night?	Yes / No	______________________
Do your joints ever swell?	Yes / No	______________________
Do you wake up with stiffness or aching in your joints or muscles?	Yes / No	______________________
Are you troubled by waking in the early hours and being unable to sleep again?	Yes / No	______________________
Are you often troubled by headaches?	Yes / No	______________________
If yes: Are they throbbing and accompanied by sickness?	Yes / No	______________________
Are you troubled with pain or aching in your stomach?	Yes / No	______________________
If yes: Is it relieved by eating or by drinking milk?	Yes /No	______________________
Have you had any persistent change in your appetite during the last three months?	Yes / No	______________________
Has your weight changed more than ten pounds (4 Kg) in the last year?	Yes / No	______________________
Are you troubled with frequent loose bowel movements?	Yes / No	______________________
Are you troubled with constipation?	Yes / No	______________________
Have you noticed any blood or mucus in your bowel movements?	Yes / No	______________________

Do you suffer with shortness of breath on exertion? Yes / No ____________________

Are you troubled by pain or tightness in your chest on exertion? Yes / No ____________________

If yes: Is it relieved by resting? Yes / No ____________________

Do you suffer with a cramp-like pain in either leg when walking? Yes / No ____________________

If yes: Do you have to stop or slow down to relieve it? Yes / No ____________________

Do you get cold hands or feet? Yes / No ____________________

Do you have varicose veins? Yes / No ____________________

Does your heart ever seem to miss a beat? Yes / No ____________________

Are you troubled with a frequent or persistent cough? Yes / No ____________________

Do you have any pain or difficulty on passing water? Yes / No ____________________

Are you passing water more frequently lately? Yes / No ____________________

Have you any lumps, cysts, or unusual swellings anywhere on your body? Yes / No ____________________

Are you easily depressed? Yes / No ____________________

Does stress seem to make your main problem worse? Yes / No ____________________

Do you have difficulty concentrating?Yes / No ____________________

Are you subject to blackout, dizzy spells, or faints? Yes / No ____________________

Do you get car/motion sickness? Yes / No ____________________

Do you have poor balance? Yes / No ____________________

Our practice specialises in treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please (circle) and complete the following:

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

____
(Signature)

____
(Print Name)

____
(Date)