Chelsea Chiropractic & Wellness

File No: _____

Welcome! Thank you for taking the time to complete the following questions to the best of your ability

Title	Surname:	Given names:	Preferred:
Date of Birth:	Occupation:	Email:	
Address:			Postcode:
Home Phone:	Mobile:	Work:	Marital Status:
Emergency Contact Name:	Mobile:	Relationship:	
How did you hear about us? (eg friend; google etc) Who may we thank:		Names and ages of children:	
Private health insurance provider:		Is this in relation to*: (Circle if applicable)* DVA / Workers Comp / Motor Vehicle*)*	

Reason for today's visit:

How long have you been experiencing the above?	Have you experienced this before? Yes / No
What makes your symptoms worse?	What makes your symptoms better?
What daily activities are affected by your symptoms?	
Were you doing anything at the time that may have caused this?	
Have you consulted other practitioners for this? Yes / No	Name / type of practitioner?
What was the result?	
Do you have any other concerns or symptoms?	

General Practitioner Name:	Contact Number:	Address:

Please list any prescription medications and dosages:	Please list any natural supplements (eg. Fish Oil, Vitamins)
Please list any operations you have had:	
Please list any serious illnesses you have had:	
Please list any trauma's, accidents, injuries you have had:	
Have you had any Motor Vehicle Accidents? Yes / No	If YES, When?
Do you smoke? Yes / No	How many per day?
Do you consume alcohol? Yes / No	How much per day / week?

What are your goals and expectations for your health?

Please mark the level of pain you are experiencing on the scale

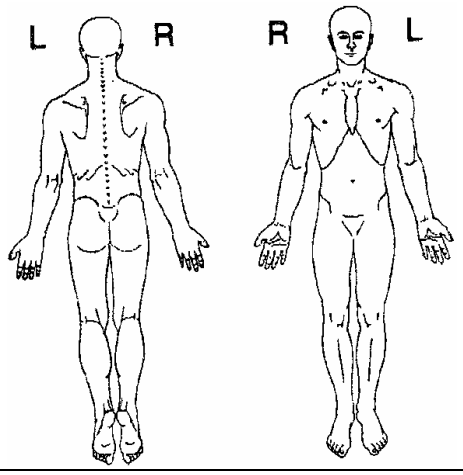
0 5 10

Please mark on the scale below where you feel you are in relation to your state of health

0% 50% 100%

(0%=not healthy, 100% extremely healthy)

Please mark on the diagram below the areas of concern:



Please tick if you have or had any of the following as chiropractic may assist:

	Past	Present
Eye disorders		
Migraines		
Headaches		
Dizziness		
Loss of Smell		
Sinus		
Hay fever		
Ear disorders		
Sore throats		
Asthma		
Poor respiration		
Chronic cough		
High blood pressure		
Low blood pressure		
Chest pain		
Reflux/Heartburn		
Indigestion		
Nausea/Vomiting		
Stomach tension		
Ulcers		
Abdominal pain		
Digestive problems		

	Past	Present
Constipation		
Diarrhoea		
Urinary disorders		
Bed wetting		
Menstrual issues		
Sexual disorders		
Skin disorders		
Sleeping disorder		
Frequent cold/flu		
Cold hands/feet		
Hot flushes/fever		
Low pain threshold		
Chronic fatigue		
Seizures/Fainting		
Stroke		
Heart disease		
Arthritis		
Osteoporosis		
Diabetes		
Respiratory issues		
Cancer		

	Past	Present
Chronic irritability		
Depression		
Anxiety/Nervous		
Neck pain		
Neck stiffness		
Shoulder pain		
Shoulder stiffness		
Arm pain		
Elbow pain		
Pins/needles hand		
Mid back pain		
Rib pain		
Low back pain		
Low back weak		
Low back stiff		
Buttock pain		
Upper leg pain		
Knee pain		
Lower leg pain		
Leg cramps		
Pins/needles leg		
Ankle pain		
Foot pain		
Pins/needles feet		

I have read and understand the Office Fee Policy document. I understand that as part of clinic policy, if cancellation or rescheduling is not given by 4pm on the day prior to my appointment, the full amount will be charged.

Patient Signature: _____ Date: _____