VITAL FAMILY CHIROPRACTIC MASSAGE FORM

Name: ______________________________________ Date of Birth ___________

Address________________________________ Suburb__________________________

Postcode_______ Phone (H)_____________ (Mob)_______________________________

Email______________________________ Male / Female — Are you pregnant? Yes / NO

Occupation:__________________________ Previous:____________________________

Next of Kin:_______________________________ Relationship:__________________

Children (names & ages) ______________ /___________________/_____________________

Conditions you are taking for?____

Hobbies / Interests? ____

Please tick the following symptoms that you have experienced in the last 6 months

☐Lower back pain	☐Tension across the shoulders	☐Nervous
☐Pain between the shoulders	☐Pins or needles in arms or legs	☐Difficulty Sleeping
☐Neck pain	☐Dizziness	☐Allergies
☐Migraine Headaches	☐Ringing in ears	☐Digestive problems
☐Tired / Fatigued	☐Tension headaches	☐Weight trouble

Which of the above is worse? ___________________How long have you had it?_________

What treatment have you had? ____

How did these treatments help?____

Have you ever had a serious car accident , fall or sports injury?

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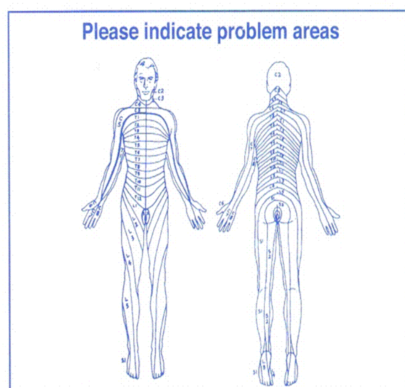

Have you seen a Chiropractor before? YES / NO

Name of Chiropractor? __________________________

What were you being adjusted for? _________________

How many adjustments were given?_________________

When was your last adjustment? __________________

How would you rate your experience?

☐Excellent ☐Satisfactory ☐Unsatisfactory

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