Welcome to our office

We endeavor to serve you in the best way possible so that your health outcomes are met. We ask that you assist us by completing the following information.

Today's Date ___/___/ 20__

Title: _____ Last Name __________________ First Name _____________________________

Preferred Name _______________________

If Under 18 – Mother's Name ______________________ Fathers Name _________________________

Address ____

Suburb _______________________________ P/Code _______

H.Phone ___-______-______ W.Phone ___-_____-_____ Mob.Phone _____- ______- _____- ______

Email address: ____

Date of Birth _____/______/_____ Age ______ Relationship Status __________________________

Occupation ____

Have you ever received chiropractic care? Yes □ No □ When? _____________

From whom? _______________Did it help? Yes □ No □ Were x-rays taken? Yes □ No □

Name of GP____________________________ GP Clinic ___________________________________

Partner's Name ________________________ Partner's Occupation _________________________

Names & Ages of Children ____

____

Referred by:

Family or friend □ Name: _______________________________

Professional Referral □ Name: _______________________________

Internet Search □

Driving past Practice □ Social Media □

Insurance Provider □ Marketing Event □

Promotional Flyer □ Promotional Flyer □

BNI □ Other □ _____________________________

Do you have Southern Cross private health care? □ Date of Renewal: ____ / ____ / ____

Do you require more information regarding private health insurance in our office? Yes □

Your History

Throughout your life you experience many stressors. Whilst some of these stressors may have seemed small, they often have an accumulative effect on our life. **Please answer** the following questions on the following areas of your life, which commonly arise during the formative years, to the best of your ability.

Pre- Pregnancy

Did your Mum and Dad…	Yes	No	Unsure
Plan and welcome the pregnancy	☐	☐	☐
Prepare their bodies for pregnancy	☐	☐	☐

Pregnancy

Did your Mum…	Yes	No	Unsure
Have chiropractic care during pregnancy	☐	☐	☐
Exercise throughout pregnancy	☐	☐	☐
Have a nutritious diet during pregnancy	☐	☐	☐
Get injured during pregnancy	☐	☐	☐
Smoke or drink alcohol during pregnancy	☐	☐	☐
Endure Stress during pregnancy	☐	☐	☐

Birth Process

	Yes	No	Unsure
Home Birth	☐	☐	☐
Hospital Birth	☐	☐	☐
Induced labour	☐	☐	☐
Drugs during delivery	☐	☐	☐
Was the delivery long?	☐	☐	☐
Was the delivery difficult?	☐	☐	☐
Caesarean (Elective/Emergency)	☐	☐	☐

Presentation position: **Posterior, breech, correct, transverse, other** (**circle**)

Growth and Development

Physical

	Yes	No	Unsure
Physical abuse by siblings/others	☐	☐	☐
Violently pulled by arm	☐	☐	☐
Were you a head-banger?	☐	☐	☐
Did you fall on your head?	☐	☐	☐
Did you fall down stairs?	☐	☐	☐
Were you taught how to care for your spine?	☐	☐	☐
Did you have the chair pulled from under you?	☐	☐	☐

Chemical

	Yes	No	Unsure
Were you breast fed?	☐	☐	☐
Have you taken antibiotics? How many times? ___________	☐	☐	☐
Were you Vaccinated?	☐	☐	☐

Mental/Emotional

	Yes	No	Unsure
Was there communication breakdown in your household?	☐	☐	☐
Was there a loss of a close relative?	☐	☐	☐
Was there any stress in the family?	☐	☐	☐

If yes to any of the above, please give details

____

Current Lifestyle

	Yes	No	Unsure
Do you Smoke?	☐	☐	☐
Do you drink alcohol?	☐	☐	☐
Do you drink adequate water?	☐	☐	☐
Do you eat healthy foods?	☐	☐	☐
Are your teeth healthy?	☐	☐	☐
Do you sleep well?	☐	☐	☐
Do you exercise regularly?	☐	☐	☐
Are you physically stressed?	☐	☐	☐
Are you being, or have you been, exposed to chemicals?	☐	☐	☐

Sports:___________________________________ Hobbies: ______________________________________

Have you been in a car accident/s before? Yes ☐ No ☐ When? _______________________________

Other accidents:____

Surgery:____

Medications you take now: ☐Blood Pressure ☐Pain Killers ☐ Sleeping Pills ☐ Insulin ☐ Birth Control ☐ Sinus/Hayfever ☐ Cholesterol ☐ Thyroid ☐ Depression/Anti-Anxiety ☐ "The Pill"
☐ Other (please list)____

Supplements you take now: ☐ Fish Oil ☐ Vit D ☐ Probiotics ☐ Magnesium ☐ Multi Vit ☐ Vit B ☐ CoQ10

Have you experienced a loss in the past 5 years? (e.g. relationship, family, business, financial)
____

Health Objectives

People consult this office with one or more of the following health objectives. Please indicate which apply to you.

- ☐ Relief of my symptoms
- ☐ Correction of my underlying problems
- ☐ To maximize my health
- ☐ To maximize myself, my familys' and community health.

How would you rate your overall health? ___ / 10
What would you like your health to be? ___ / 10

Have you ever suffered from any of the following conditions: (please circle all that apply to you)

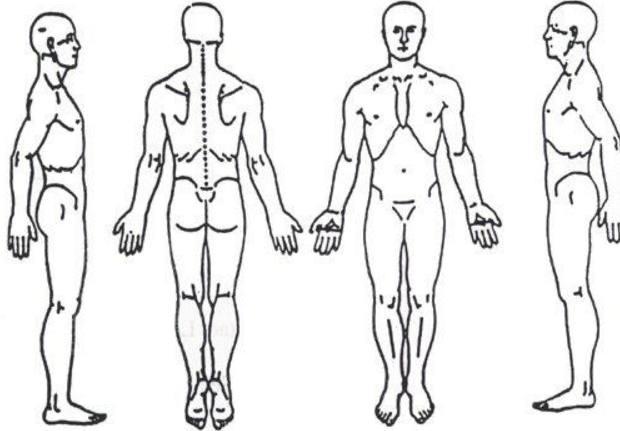
Dizziness	Fatigue	Headaches	Loss of sleep
Pain at night	Low back pain	Sciatica	Swollen Joints
Asthma	Frequent colds	Difficulty breathing	High blood pressure
Low blood pressure	Chest pain	Poor circulation	Anemia
Stroke	Pleurisy	Aids	Frequent urination
Prostate trouble	Lumps in breast	Diabetes	Cancer
Migraines	Loss of Libido	Sinus	Period Pain

Your Current Problem

You may have specific reasons for consulting this office. If so, please list below in order of severity?

1. ____ For how long? ______________________
2. ____ For how long? ______________________
3. ____ For how long? ______________________

Please mark on diagram your areas of concern



Why do you think the problem started? _______________

Was it the result of an accident Yes □ No □ Date: _________ Location: __________________

Please describe any activities that may be causing these problems:____________________________

Does anything help relieve it? _______________________

Has it been **getting better**, **worse** or **staying the same** (circle)

Have you had this problem before? Yes □ No □ If so when? ________________________________

Please rate your pain out of 10. _______________________ **(O = no pain, 10 = worst pain)**

What type of pain is it? (e.g. burning, stabbing, aching) ____

Does the pain travel anywhere? Yes □ No □ If so where to?______________________________

Tingling in either arm or leg? Yes □ No □ If so where to?______________________________

Numbness in either arm or leg? Yes □ No □ If so where to?______________________________

Weakness in either arm or leg? Yes □ No □ If so where to?______________________________

Is the pain **constant** or **off/on**? (circle)

Is it worse in the **morning**, **lunchtime**, **afternoon**, **evening**, or **when you sleep**? (Please circle all that apply to you)

Have you seen anyone else for these problems? Yes □ No □
If yes, who? _____________________________ when? __________________________________

What are these problems stopping you from doing or achieving?
(e.g. walking, working, sport, travel, family time, relaxing, hobbies)

1. _______________________________________
2. _______________________________________
3. _______________________________________