CONFIDENTIAL PATIENT HEALTH R[illegible] DATE

PERSONAL HISTORY

Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Name: ______________________________

Home ☎: ____________________________

Mobile ☎: ___________________________

Business ☎: _________________________

Address: ____________________________________

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Birth Date: ____________________ Age: _______

Marital Status: ______________________________

Ages of Children: ____________________________

E-mail: ____

Current Occupation: ____

How did you hear about Get Back Health Chiropractic Clinic? ____

Name of Doctor & contact details: ____

CURRENT HEALTH CONDITION

Purpose of this appointment: ____

When did this condition begin? ______________ Has this condition occurred before? Yes ☐ No ☐

Is the condition: Job Related ☐ Car Accident ☐ Home Injury ☐ Fall ☐ Other ☐ _________________________

Have you had any previous treatment for this condition: Yes ☐ No ☐ With Whom: ________________________

Type of treatment: __________________________ Results: _____________________________________

Please list any medication and/or vitamins/supplements you are taking?: Nerve Pills ☐ Pain Killers ☐

Muscle relaxants ☐ Blood Pressure Medicine ☐ Insulin ☐ Other ____________________________________

Please list any conditions under current medical care: ____

Do You Intake: Cigarettes ☐ Per Day? ______ Alcohol ☐ Units per Week? _______ Caffeine ☐ ________

PAST HEALTH HISTORY

Major Surgery/Operations:

Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Knee Surgery ☐

Pelvic Surgery ☐ Other ☐ ____

Please list any past accidents/falls____

Please list any fractures/ dislocations____

Please list any visits to hospital (other than above): ____

Date of last physical examination by doctor: ____

Have you previously had Chiropractic care: Yes ☐ No ☐

Doctor's name & approximate date of last visit: ____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Thyroid	☐ Eczema	**DETAILS:**____________________
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Asthma	☐ Measles	__________________________
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Anaemia	☐ Heart Disease	__________________________
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Cancer	☐ Whooping Cough	__________________________

Have you been tested HIV positive? ☐ Yes ☐ No

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain or Stiffness
☐ Leg pain
☐ Walking Problems
☐ Difficulty Chewing or Clicking Jaw
☐ General stiffness

NERVOUS SYSTEM

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion or Depression
☐ Fainting
☐ Convulsions
☐ Cold or Tingling Extremities
☐ Stress

GENERAL

☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches
☐ Hayfever

GASTRO-INTESTINAL

☐ Poor or Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhoea
☐ Constipation
☐ Haemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems

☐ Weight Problems

☐ Abdominal Cramps

☐ Gas or Bloating After Meals

☐ Heartburn

☐ Black or Bloody Stool

☐ Colitis

GENITO-URINARY

☐ Bladder Trouble

☐ Painful or Excessive Urination

☐ Discoloured Urine

☐ Urinary Tract Infection

CARDIOVASCULAR

☐ Chest Pain

☐ Short Breath

☐ Blood Pressure Problems

☐ Irregular Heartbeat

☐ Heart Problems

☐ Lung Problems or Congestion

☐ Varicose Veins

☐ Ankle Swelling

☐ Stroke

EARS-NOSE-THROAT

☐ Vision Problems

☐ Dental Problems

☐ Sore Throat or Throat Problems

☐ Ear Aches

☐ Hearing Difficulty

☐ Stuffed Nose

☐ Sinus Problems

MALES

☐ Prostate/ or Sexual Dysfunction

FEMALES

☐ Menstrual Irregularity

☐ Menstrual Cramps

☐ Breast Pain/ or Lumps

What was the date of your last period? ______________________

Are you pregnant?

Yes ☐ No ☐ Not Sure ☐

FAMILY HISTORY

Do any of the following members of your family have any similar problems?

Mother

Father

Brother

Sister

Spouse

Child