DATE:_____

PATIENT HEALTH QUESTIONNAIRE

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. Thank you

NAME: _____ PHONE: (H) _____

ADDRESS: _____ (W) _____

SUBURB: _____ STATE: _____ PCODE: _____ (M) _____

DATE OF BIRTH:_____ **MARITAL STATUS: S** ☐ **M** ☐ **NO. OF CHILDREN:**_____

OCCUPATION:_____ EMAIL: _____

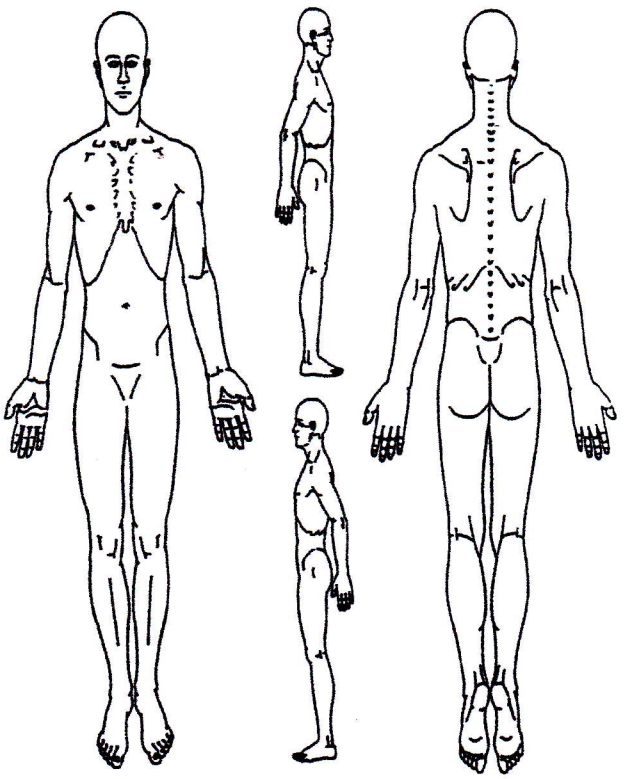
REFERRED BY: PATIENT: ☐ _____ **DOCTOR** ☐ **WEBSITE** ☐ **GOOGLE** ☐ **DROVE BY** ☐

REASON FOR THIS VISIT: describe major symptoms & complaints_____

_____

_____

AREAS OF SYMPTOMS (indicate by marking)



IS THE REASON FOR YOUR VISIT TO:

Alleviate your symptoms ☐

Correct the cause of your symptoms ☐

WHEN DID YOU FIRST NOTICE THESE SYMPTOMS:_____

WHOM HAVE YOU CONSULTED FOR THIS PROBLEM:_____

DID YOU HAVE A.

X-RAY ☐ C/T SCAN ☐ MRI ☐ ULTRA SOUND ☐

WHAT TREATMENT HAVE YOU RECEIVED?

_____

HAS THIS HAPPENED BEFORE? YES ☐ NO ☐

If so, when?_____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE:

Where?_____When?_____

DATE OF LAST PHYSICAL EXAMINATION: _____

MEDICATION YOU NOW TAKE:

PAIN KILLERS ☐ SEDATIVES ☐ BIRTH CONTROL ☐ NERVE PILLS ☐ INSULIN ☐

MUSCLE RELAXERS ☐ ANTI INFLAMATORIES ☐ BLOOD PRESSURE ☐ OTHER_____

HAVE YOU BEEN IN A ROAD ACCIDENT? CAR ☐ TRUCK ☐ MOTORBIKE ☐ BICYCLE ☐ PEDESTRIAN ☐ DATE: _____

HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT? When: _____

PREVIOUS MEDICAL HISTORY

HAVE YOU EVER / WHEN: Been knocked unconscious _____ Been treated for spinal or nerve disorder _____

Had a fractured bone _____ Been hospitalised other than for surgery_____ had surgery_____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE SUFFERED FROM:

Alcoholism ☐ diabetes ☐ heart disease ☐ polio ☐ cancer ☐

anaemia ☐ eczema ☐ miscarriage ☐ pheumatic fever ☐ goiter ☐

arthritis ☐ emphysema ☐ measles ☐ stroke ☐ pleurisy ☐

asthma ☐ epilepsy ☐ mumps ☐ tuberculosis ☐ ulcers ☐

HAVE ANY MEMBERS OR YOUR FAMILY ie PARENTS /GRANDPARENTS SUFFERED FROM THE FOLLOWING:

Diabetes ☐ heart problems ☐ circulatory problems ☐ cancer ☐ lung problem ☐ arthritis ☐

*This is a **CONFIDENTIAL HEALTH REPORT.***

*Please check the appropriate box for any of the following symptoms **(O = occasionally, F = Frequent)** which you now have or have had previously.*

O	F	GENERAL
__	__	Allergy
__	__	Convulsions
__	__	Dizziness
__	__	Fainting
__	__	Headache
__	__	Neuralgia
__	__	Numbness
		MUSCLE & JOINT
__	__	Arthritis
__	__	Bursitis
__	__	Foot trouble
__	__	Low Back pain
__	__	Neck pain or stiffness
__	__	Pain between shoulders
		PAIN OR NUMBNESS IN:
__	__	Shoulders
__	__	Arms
__	__	Elbows
__	__	Hands
__	__	Hips
__	__	Legs
__	__	Knees
__	__	Feet
__	__	Sciatica
__	__	Swollen joints
		SKIN
__	__	Bruise easily
__	__	Dryness
__	__	Skin eruptions (rash)
__	__	Varicose Veins

		GASTRO-INTESTINAL
__	__	Colon trouble
__	__	Constipation
__	__	Diarrhoea
__	__	Difficult digestion
__	__	Distension of abdomen
__	__	Gall bladder trouble
__	__	Haemorrhoids
__	__	Liver trouble
__	__	Pain over stomach
		EYES, EARS, NOSE & THROAT
__	__	Asthma
__	__	Colds
__	__	Deafness
__	__	Earache
__	__	Ear discharge
__	__	Ear noises
__	__	Eye pain
__	__	Nasal obstruction
__	__	Nosebleeds
__	__	Sinus infection
		CARDIO-VASCULAR
__	__	Hardening of arteries
__	__	High blood pressure
__	__	Low blood pressure
__	__	Pain over heart
__	__	Poor circulation
__	__	Rapid heart beat
__	__	Slow heart beat
__	__	Swelling of ankles

		RESPIRATORY
__	__	Chest Pain
__	__	Chronic cough
__	__	Difficulty Breathing
__	__	Spitting blood
__	__	Spitting up phlegm
__	__	Wheezing
		GENITO-URINARY
__	__	Bed wetting
__	__	Blood in urine
__	__	Frequent urination
__	__	Kidney infection and stones
__	__	Painful urination
__	__	Pus in urine
		FOR WOMEN ONLY
__	__	Cramps or backache
__	__	Excessive menstrual flow
__	__	Hot flushes
__	__	Irregular cycle
__	__	Lumps in breast
__	__	Menopausal symptoms
__	__	Painful menstruation
		FOR MEN ONLY
__	__	Prostate trouble
__	__	Poor urinary flow
__	__	Impotence
__	__	Testicular pain

LIFESTYLE PROFILE

What do you want to gain from Chiropractic Care? _____

What are your ultimate health goals / desired outcome? _____

What is your passion in life? Hobbies / Special interests? _____

Please sign here to indicate that all the information given on this form is accurate. _____ DATE: _____

THANK YOU AND WE LOOK FORWARD TO BEING PART OF YOUR HEALTH CARE TEAM