STOTT CHIROPRACTIC

HEALTH HISTORY QUESTIONNAIRE

Welcome to our office

All questions in this questionnaire are strictly confidential and will become part of your record.

Name: _____ Today's date: ___/___/___
Title First Name Surname

Preferred Name: _____ Date of birth: ___/___/___

Address: _____
Street # Street Name Suburb Postcode

Home phone: _____ Work phone: _____

Mobile phone: _____ Email address: _____

Occupation: _____ Employer: _____

Emergency contact: _____
Name Number

Have you had chiropractic care before? ☐ No ☐ Yes – If yes, when was your last visit?_____

If yes, where did you go? _____

Have you had any of the following? ☐ XRAY ☐ MRI ☐ CT Scan ☐ Other imaging_____

If yes, please specify: _____

Are you a member of a private health fund? ☐ No ☐ Yes

If yes, Fund Name: _____

Is your chiropractic covered by workers compensation or ICWA (motor vehicle insurance)? ☐ No ☐ Yes

We appreciate referrals. How did you find out about our clinic?

☐ Stott Chiropractic Website ☐ Facebook

☐ Internet/Google ☐ Sign

☐ Yellow Pages ◦ online ◦ print

☐ Another Health Professional, please specify: _____

☐ Family member, please specify: _____

☐ Friend, please specify: _____

Marital Status: Single Partnered Married Separated Divorced Widowed

Spouse/Partner's name: _____ Number of Children: _____ Ages:_____

Would you like to receive our Newsletter? ☐ Yes ☐ No

Daily Activities

Tick which of the following are part of your regular daily activities:

☐ Sitting ☐ Walking ☐ Heavy lifting ☐ Computer work
☐ Writing ☐ Driving ☐ Manual work ☐ Repetitive tasks
☐ Standing ☐ Phone use ☐ Desk work ☐ Emotional stress

Sleeping posture: ☐ Side ☐ Back ☐ Stomach

Sports you play/used to play: _____ ☐ Currently play ☐ Used to play
_____ ☐ Currently play ☐ Used to play

Are you trying to: ☐ Gain Weight ☐ Lose Weight ☐ Neither

How often do you exercise? _____

Do you smoke? ☐ No ☐ Yes: _____per day

Do you sleep well? ☐ No ☐ Yes Approx hours of sleep per night_____

Do you use medications? ☐ Never ☐ Occasionally ☐ Often (prescriptive or non-prescriptive)

With regard to any medications you currently use (or have recently used), please list. Include name, dosage and reason.

_____

_____

_____

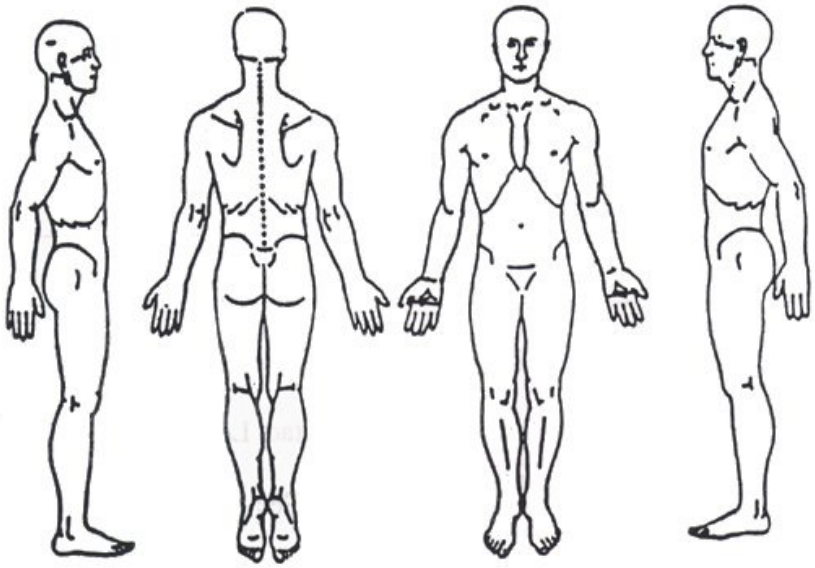
_____

Present State of Health

Please tick if you have had any of the following in the last 30 days

☐ Pain worse at night ☐ Loss of bladder control ☐ Unexplained weight loss ☐ Surgery
☐ Bacterial infection ☐ Fever and/or cold chills ☐ Constant pain unrelated to movement

Please describe and mark on the diagram the location of your chief complaint:



How long has the pain been bothering you? _____

What do you think caused it? _____

Describe the pain:

☐ Dull ☐ Sharp ☐ Aching ☐ Burning ☐ Numbness ☐ Pins and Needles

Is the pain: ☐ Constant ☐ Intermittent

Does the pain radiate anywhere? ☐ No ☐ Yes –If yes, where? _____

What makes the pain better? _____

What makes the pain worse? _____

Describe any trauma/accidents you have had: _____

Describe any surgeries you have had: _____

Please tick any other symptoms you have had in the past

☐ Dizziness	☐ Tension	☐ Ringing in ears
☐ Headaches	☐ Neck pain	☐ Digestion problems
☐ Allergies	☐ Menstrual pain	☐ Fainting
☐ Sleeping problems	☐ Fever	☐ Fatigue
☐ Nervousness	☐ Chest pain	☐ Depression

Is there any chance that you could be pregnant? YES NO

(Please inform your chiropractor if you are unsure).

Signature: _____ Date: _____