Patient case History
All information contained in this Questionnaire is strictly confidential

thornton CHIROPRACTIC

Full Name:		DOB
Address:		
Phone:	(w) (m)	(h)
Email Address:		
Occupation:		
Emergency contact:	Name: Number:	
Health Fund Details if applicable		

How did you hear about us? Friend Family who:_____ walk by google website other _____

YOUR HEALTH PROFILE

Why this form is important ?

Health (or lack of) is constantly changing over time. Throughout life, stressors occur (physical,chemical, emotional). These affect your nervous system and may cause pain or other symptoms. **Help us to help you** by answering the following questions.

If you have ever had chiropractic care please complete the following:

Name of Chiropractor: Location:

Why did you seek chiropractic care? Date of last adjustment:

What were the results of your care: Excellent Satisfactory Fair Did not help Worsened
(pls circle an option)

Did the chiropractor request X-Rays? Y N Did you have a thorough examination? Y N

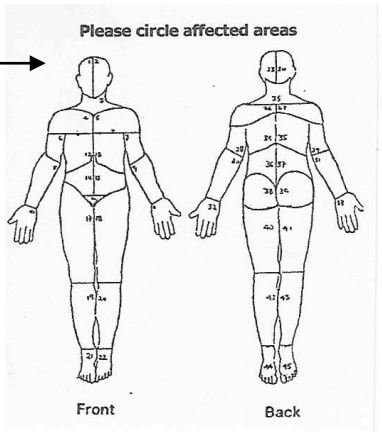
Please tick next to the options below that apply to you

If you are experiencing discomfort, is it?	Sharp	Dull	Comes and goes	Constant
Since the problem started, is it?	About the same	Getting better	Getting worse	
It interferes with:	Work	Sleep	Hobbies	Leisure Other
If other please describe:				

Please circle all the symptoms you have ever had, even if they do not seem to relate to your current problem:

Back Discomfort	Constipation/Diarrhea	Headaches
Nausea/Vomiting	Persistent cough	Blurred vision
Depression	Indigestion	Neck stiffness
Pins and needles in arms	Bowel or bladder problems	Dizziness/Fainting
Loss of balance	Numbness in fingers	Pins and needles in legs
Chest discomfort	Fatigue	Menstrual irregularity
Numbness in toes		

** ***Please Complete***



Currently your symptoms are aggravated by ?			
Bending	Reaching	Standing	Coughing
Sitting	Walking	Lifting	Sneezing
Other	Neck Movement	Straining at stool	

The Beginning Years (to age 17)

Did you participate in aggressive youth sports? YES NO Unsure

Did you have any childhood illnesses? YES NO Unsure

Was there any prolonged use of medications such as antibiotics or an inhaler? YES NO Unsure

As a child, were you under regular Chiropractic care? YES NO Unsure

Did you have any serious falls/injuries as a child? YES NO Unsure

Did you have an surgery? YES NO Unsure

If Yes, WHAT and WHEN:

Adult (18 years to present)

Have you had any serious health problems? YES NO Unsure

If Yes, What and When:

Have you been in any motor vehicle, motor bike accidents or major falls? YES NO Unsure

If Yes, What and When:

Have you fractured or broken any bones? YES NO Unsure

If Yes, What and When:

On a scale of 1-10, describe your stress levels (1=zero 10=extreme) Occupational: Personal:

On a scale of **Poor Good Excellent** describe your: Diet: Exercise: Sleep: General health:

Have you ever had any surgery or been in hospital? YES NO Unsure

If Yes, What and When:

	Never	Occasionally	Moderately	Excessive
Alcohol				
Smoking				
Coffee				
Sodas				

Are you currently taking the following ?

Anti - inflammatory	Muscle relaxants	Medications for any discomfort
Anti - depressants	HRT	Vitamins
Birth Control	Other, please list:	

Medical Doctors Name: Contact number:

Family Health Profile

At our office we are not only interested in your health and well-being, but also that of your family and loved ones. Please mention below any health conditions or concern you may have about your:

Mother: Father:

Spouse: Children:

Others:

Lifestyle Profile

What do you want to gain from Chiropractic

What are your ultimate health goals/desired outcomes?

What is your passion in life? Hobbies/special interests.

For Women

Are Pregnant? YES NO Unsure Date of last menstrual cycle:

Please circle if you have the following: Tender breasts Lumps in breasts Period discomfort

Irregular periods Hot Flushes Discomfort during intercourse Bleeding between periods

Excessive menstrual flow Vaginal discharge

Please Read and Sign

The statements made on this form are accurate to the best of my recollection and I agree to allow this practice to examine me for further evaluation. I also acknowledge that I am informed about the missed appointment policy below.

Patient's/Guardian's Signature: Date:

The best compliment is a referral !

Fee Structure:

Patient Type	First consultation	Follow ups	
Adult 18yrs +	$85.00	$58.00	
Child	$65.00	$43.00	
Student	$75.00	$43.00	
Concession	$80.00	$53.00	

Missed appointment Policy - please read

A fee of $25.00 for appointments may be charged if you fail to attend an appointment.

If less than 2 hrs notice is given for a cancellation, a cancellation fee will be charged.

Should the insurance claim be rejected in any manner, the patient is responsible for any and all payments of accounts at Thornton Chiropractic Clinic.

INFORMED CONSENT

Chiropractic care is well recognised as being an extremely safe and effective method of care for many conditions. Chiropractors complete a 5 year, full time university degree to become a registered practitioner. However, as with all health care professionals, there is a small risk of injury, including although not limited to; muscle and joint soreness, strains and sprains (to a ligament or disc in the neck 1 in 139,000 or low back 1 in 62,000), fractures, strokes or stroke like symptoms (1 in 5.85 million neck manipulations) and an exacerbation and / or aggravation of an underlying condition.

As part of your Chiropractic care, re-examinations are conducted to monitor your health improvements.

I hereby give consent to receive Chiropractic care from a registered Chiropractor and agree to undergo re-examinations if and when required.

Full Name: _____ Date: _____

Signature: _____

Chiropractors Name: _____ Date: _____

Signature: _____

Welcome to Chiropractic,

Please feel free to ask questions at any stage of your care.