a Level 7, Unit 47 / 4-10 The Boulevarde Brighton-le Sands
t 02 9559 6554 e info@jrchiropractic.com.au w WWW.JRCHIRORPACTIC.COM.AU

Initial Consultation Form

Full name:		DOB:	
Home Address:		Mobile:	
Occupation:		Email:	
Marital Status :			

Next of Kin Details	Name :		Contact Number:
	Relationship:		Children (ages):

Who referred you to JR Chiropractic? (Please help us thank and reward the person who referred you)
....

What has brought you to JR Chiropractic and how do you hope to benefit from the care given here? (Please tick all that apply)

☐ Symptom relief ☐ Less tension/increased flexibility ☐ Better posture ☐ Personal growth ☐ Improved health and wellbeing ☐ Improved ability to cope with stress ☐ Greater energy levels ☐ Continuing care – Please describe...

Please describe your present problem/s:
....

When did this problem start? .... What were you doing? ....

What makes it worse? .... What makes it better? ....

Describe the feeling you have with this problem (please circle)

Health check (No Problem) Sharp Pain Dull Pain Ache Weak Throbbing

Numb Shooting Gripping Burning Tingling

How frequent is it? (Circle): Constant (100%) Frequent (>50%) Occasionally (25%-49%) Intermittent (< 25%)

How would you describe the intensity now? 0_ 1_ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10
No Pain Unbearable

Are your symptoms (Circle): Increasing Decreasing Not Changing

Are your symptoms worse (Circle): in the morning / afternoon / increasing through the day / same all day

Have you been treated for this problem before? .... Who by: ....

Have you had previous Chiropractic care? ☐ No ☐ Yes - When was your last consultation? ....

Have you had a similar problem before? .... How was it cared for? ....

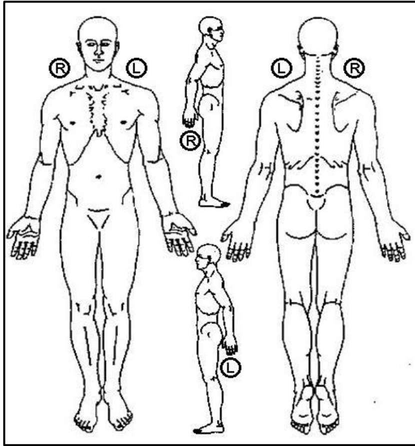
Please list any current medications / supplements and your reasons for taking them:

....

JR CHIROPRACTIC
HEALTH CENTRE

a Level 7, Unit 47 / 4-10 The Boulevarde Brighton-le Sands
t 02 9559 6554 e info@jrchiropractic.com.au w WWW.JRCHIRORPACTIC.COM.AU

Please mark on these pictures where you have pain or other symptoms:



Family History: Has any of your immediate family had any of the following conditions (Circle)? Cancer Blood Pressure Diabetes Stroke Heart Trouble Migraine Other

Please describe: ……………………………………………………….

Do you have any physical, emotional or mental symptoms other than those you've just listed?

What is your stress level like (1 minimal, 10 Major/burnout) in:

Work…………. Home Life: ………………… financial: ……………. Health: ………………….

Other: …………….

Do you smoke? .... How Much? ………………. Do you drink alcohol? …………………. How much per week? ……………..

Are you pregnant? (How many months?)... Have you had a baby recently? (Date)...............

Do you make any repetitive movements or hold any prolonged postures during the course of your day? (at work, at home, in sports & hobbies, etc.)

…….

………

Systems Review. Do you have now, or have you ever had, any problems of the following (please tick):

☐ Headaches ☐ Dizziness ☐ Vertigo ☐ Blurred Vision ☐ Ears Ringing ☐ Night Pain ☐ Heart trouble ☐ Arthritis ☐ Unexplained weight loss ☐ Serious Illness ☐ Cancer ☐ Heart Attack ☐ Bronchitis ☐ Asthma ☐ Allergies ☐ Osteoporosis ☐ Nausea ☐ Diarrhea ☐ Constipation ☐ Incontinence ☐ Urinary Tract Infection ☐ Menstrual Problems ☐ Fractures/accidents ☐ Trouble sleeping ☐ depression/anxiety ☐ cold or heat intolerance

Please describe...

Name of your regular GP? ……………………………………………………………………

Where can we contact her / him if necessary: ……………………………………………………………………….

CONSENT FOR COLLECTION, USE AND DICLOSURE OF PERSONAL INFORMATION INCLUDING SENSITIVE AND HEALTH INFORMATION

Information is collected from you in a lawful manner fairly and without ensue intrusion. JR Chiropractic uses information only for the purposes for which it was collected or a related purpose.

Patient Name____ Date _______________________

Patient Signature____

(Or Guardian if patient is a minor)