Welcome to City Chiropractic

In order to provide you with professional
and efficient chiropractic care, we require some personal details.
Please take a moment to read and complete this form.

**Name**: _____ Like to be called: _____

Date of Birth: _____ Age: _____

Do you have children? _____ Their ages: _____

**Address:**
Home: _____ Suburb: _____

Postal: _____ Suburb: _____

Phone: Hm: _____ Wk: _____ Mobile: _____

Email: _____

Occupation: _____

How were you referred to City Chiropractic? Please tick one of the following:
Website____ Friend____ Relative____ GP____ Yellow Pages____ Signage___Coupon___

If you ticked website or yellow pages, what was your search word? _____
If you ticked friend or relative, could you please write their name, as we like to reward referrals _____

What is the reason for your visit with us today? _____

Have you had any previous treatment? Eg, Physio, Massage etc _____

Have you had previous Chiropractic care? If yes, with whom? _____

Chiropractic is a process that involves the adjustment of your spine to improve spinal function and in turn reduce irritation to your nervous system.
The nervous system impacts on every muscle, organ and tissue in your body and for this reason it is necessary to complete a full orthopaedic and neurological assessment.

This process involves:

1. An interview which will include your complete health history.
2. An orthopaedic and neurological examination.
3. Spinal x-rays – if deemed necessary.

Your next visit will involve a report of findings where the results of your examination will be discussed and a care plan will be suggested.
Thank you for completing this form.

Patient consent: _____ Date: _____

Health Questionnaire: Name _____Date_____

Are you a smoker? _____Do you drink alcohol? ____units per day ____per week_____

When was the last time you visited a medical doctor? _____ For what purpose? _____

What exercise do you do each week? _____

Does your job include any manual lifting? _____, computer use? _____stress? _____

Have you ever had any surgery in the past? _____

Types of Surgery_____ age when occurred_____

_____ _____

Have you ever been treated for any illness? _____

Which type of illness? _____ age when occurred_____

_____ _____

Is there any family history of heart disease, cancer, diabetes or any other hereditary condition?

If yes, what type _____

Are you taking any medication?_____ What type?_____

Do you take any vitamins, supplements or natural remedies? _____ What type? _____

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Have you ever been treated for any injuries? _____ What type, and how old were you?

_____

Have you ever broken any bones? _____Which ones and how old were you?_____

_____

Do you sleep on your back, side, or stomach? _____Do you sleep well? _____

Have you ever been diagnosed with a stroke or heart problem? _____

Do you have blurred vision, dizziness or ringing in the ears? _____

Do you suffer from headaches? _____Migraines?

Do you have any digestive problems? _____

Have you ever had an Xray?_____

Are you pregnant or attempting to become pregnant?_____