

PERSONAL DETAILS

Please use a black pen only as our scanner will only pick up black pen

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Name Dr / Mr / Mrs / Ms _____

Address _____

Postcode _____

Phone Home _____ Work _____ Mobile _____

Email _____

Birthdate _____ Occupation _____

Partner's name _____ No. of children _____

What Health fund do you belong to? _____

YES **NO** Are you covered for chiropractic care (we need to know this as some health funds require specific item numbers)?

Is this related to a claim? **Workers Compensation** **Third Party Claim** **Neither**

Who is your regular doctor (General Practitioner)? _____

We are grateful that our practice grows by referral.

Who may we thank for referring you? _____

Have you ever seen a Chiropractor before?

YES **NO** Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating your spine and neurological function.

Major Complaint

What is your main problem? _____

When and how did it start? _____

Was there any of the following prior to or during the onset?

Illness / infection Trauma Other significant event _____

NO **YES** Are your symptoms worse at night?

NO **YES** Is your problem getting worse?

What relieves your symptoms? _____

What makes your symptoms worse? _____

Are your symptoms worse at night or any specific time of the day? _____

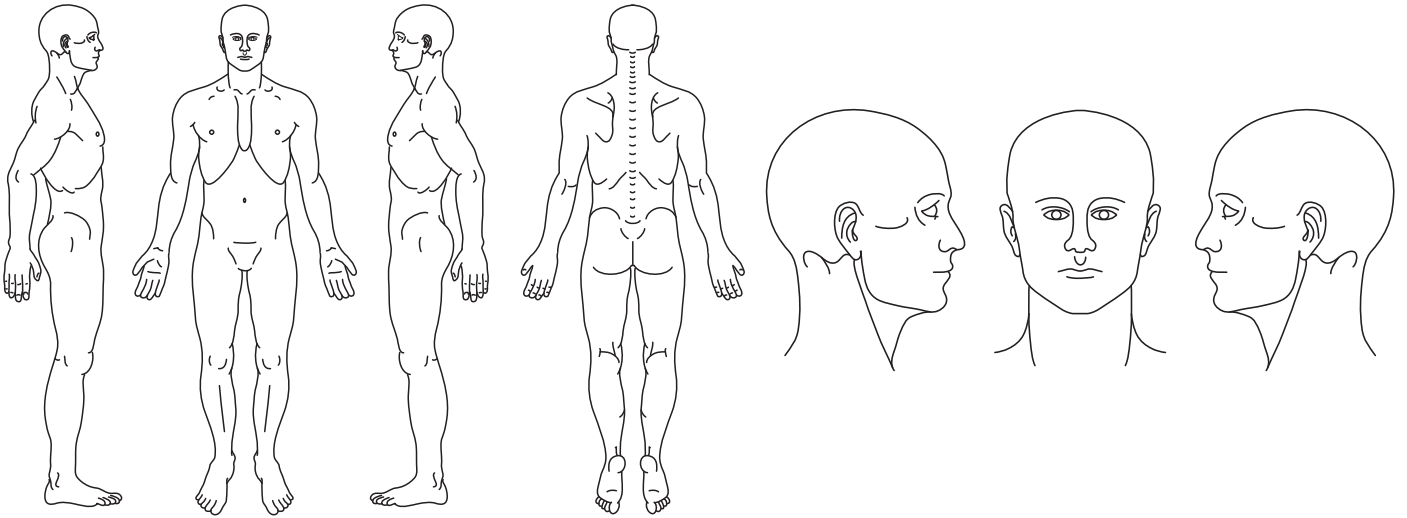
NO **YES** Do you have any pain traveling down your arms or legs? **If yes, describe:**

Does your current problem involve any of the following?

- NO YES Tingling in either arm or leg? _____
- NO YES Numbness in either arm or leg? _____
- NO YES Weakness in either arm or leg? _____
- NO YES 'Weird' sensations in either arm or leg? _____
- NO YES Have you had any other treatment for your current problem? _____

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern:



Medical History & General Health

Please tick Yes/No, describe where applicable:

- NO YES Did you / Do you smoke? _____
- NO YES Did you / Do you drink alcohol? _____
- NO YES Did / Do you take recreational drugs? _____
- NO YES Do you think you have a healthy diet? _____
- NO YES Do you take vitamin supplements? _____
- NO YES Do you exercise regularly? _____
- NO YES Have you had any form of surgery? _____
- NO YES Are you currently taking any form of medication? ***If yes, list all of them:***

- NO YES Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? _____
- NO YES Have you had any broken bones? ***If yes, which ones and how?*** _____

- NO YES Have you had any car accidents (no matter how trivial)? ***If yes, when and describe:***

- NO YES Have you had any falls or sports injuries? ***If yes, when and describe:*** _____

NO **YES** Have any of your family members suffered from any serious or hereditary diseases?
(e.g. cancer, diabetes, heart disease or any other major health problem)

NO **YES** Do you suffer from fatigue? _____

NO **YES** Does your heart ever seem to miss a beat? _____

NO **YES** Do you suffer with shortness of breath on exertion? _____

NO **YES** Are you troubled by pain or tightness in your chest on exertion?

NO **YES** If yes: Is it relieved by resting? _____

NO **YES** Do you suffer with a cramp-like pain in either leg when walking?

NO **YES** *If yes:* Do you have to stop or slow down to relieve it? _____

NO **YES** Are you troubled with a frequent or persistent cough? _____

NO **YES** Do you have allergy problems? _____

NO **YES** Are you troubled with pain or aching in your stomach? _____

NO **YES** *If yes:* Is it relieved by eating or by drinking milk? _____

NO **YES** Have you had any persistent change in your appetite during the last three months?

NO **YES** Has your weight changed more than 4 kilograms (10 pounds) in the last year?

NO **YES** Are you troubled with frequent loose bowel movements?

NO **YES** Are you troubled with constipation? _____

NO **YES** Have you noticed any blood or mucus in your bowel movements?

NO **YES** Are you troubled with haemorrhoids? _____

NO **YES** Do you have any pain or difficulty with passing water? _____

NO **YES** Are you passing water more frequently lately? _____

NO **YES** Do you get pain in any of your joints? _____

NO **YES** *If yes:* Is it worse in the night? _____

NO **YES** Do your joints ever swell? _____

NO **YES** Do you wake up with stiffness or aching in your joints or muscles?

NO **YES** Have you or your partner noticed any change in your personality?

NO **YES** Do you have difficulty concentrating? _____

NO **YES** Do you have any problems with memory? _____

NO **YES** Do you have any problems with hearing (including ringing in the ears)?

NO **YES** Do you have problems with smell or taste? _____

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- NO YES Have you noticed any problems with choosing words or hand writing?

- NO YES Did you / Do you have occupational stress? _____
- NO YES Does stress seem to make your main problem worse? _____
- NO YES Are you easily depressed? _____
- NO YES Do you suffer from anxiety? _____
- NO YES Do you have poor sleep? _____
- NO YES Do you grind or clench your teeth? _____
- NO YES Are you often troubled by headaches? _____
- NO YES **If yes:** Are they accompanied by sickness or other symptoms? _____
- NO YES Do you have any problems with your vision? _____
- NO YES Does one eye water more than the other? _____
- NO YES Do you get cold hands or feet? _____
- NO YES Do you have varicose veins? _____
- NO YES Have you any lumps, cysts, or unusual swellings anywhere on your body?

- NO YES Do you get twitching or cramping anywhere? _____
- NO YES Do you have any problems with sweating? _____
- NO YES Do you have poor balance? _____
- NO YES Did you / Do you suffer vertigo? _____
- NO YES Do you get car/motion sickness? _____
- NO YES Are you subject to blackout, dizzy spells, or faints? _____
- NO YES Do you have a tendency for clumsiness? _____

Is there anything else that you feel is relevant that you would like to describe?

Elite Chiropractic specialises in treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please circle and complete the following:

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

Your signature

Please print name

Dated this _____ day of _____, 20_____

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