PERSONAL AND FAMILY HISTORY

DATE: ____ / ____ / ____

Full Name: _____

Preferred Name: _____ **Date of Birth:** _____ **Age:** _____

Street Address: _____

Suburb: _____ **Post Code:** _____

Telephone: (H) _____ **(W)** _____ **(M)** _____

E-Mail: _____

Private Health Fund: _____

Occupation: _____ **Employer's Name:** _____

Gender: Male / Female **Marital Status:** _____ **Spouse / Partner's Name:** _____

Children (names and ages): _____

Are you Pregnant: Yes / No

Have you received Chiropractic care in the past? Yes / No **Approximate date of last visit?** _____

Who can we thank for recommending you to our practice? _____

Would you like to receive SMS appointment reminders? Yes / No

Do you consent to communication via emails, SMS and social networking sites? Yes / No

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CURRENT HEALTH CONDITION:

What is the main reason for your visit today? _____

When did this condition begin? _____

GENERAL HEALTH HISTORY:

Often accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

List any surgery and approximate dates: _____

_____

List any falls, accidents / injuries, fractures, dislocations: _____

_____

Have you previously had x-rays taken? Area of body and when? _____

_____

STRESSORS:

The accumulation of stress affects our health and ability to heal. Please list your top 3 stresses (you have ever had) in each category:

1. **Physical stress (falls, accidents, injuries, work postures, lifting)**

   a. _____ b. _____ c. _____

2. **Bio-chemical (smoke, unhealthy food, not drinking enough water, drugs/alcohol, pollutants/chemicals in environment)**

   a. _____ b. _____ c. _____

3. **Psychological or mental/emotional stress (work stress, relationship stress i.e. divorce, financial stress, self esteem, etc.)**

   a. _____ b. _____ c. _____

PAST HEALTH HISTORY:

Please CIRCLE any symptoms you have currently: (if you have experienced these symptoms in the past, place a ✓ in the box)

▢ Arm Pain	▢ Diarrhea	▢ Migraines	▢ Heartburn / Indigestion
▢ Constipation	▢ Hernias	▢ Irritable	▢ Leg Numbness / Tingling
▢ Buttocks Pain	▢ Eczema	▢ Headaches	▢ Frequent Urination
▢ Diabetes	▢ Gout	▢ Miscarriage	▢ Shoulder Pain / Stiffness
▢ Eye Disorders	▢ Mood Swings	▢ Cancer	▢ Recurrent Sore Throats
▢ Bedwetting	▢ Heart Attack	▢ Hand Pain	▢ Finger Numbness / Tingling
▢ Sexual Disorders	▢ Ringing in Ears	▢ Asthma	▢ Low Back Pain / Stiffness
▢ Stroke	▢ Nausea	▢ Arthritis	▢ Irregular / Painful Periods
▢ Leg Pain	▢ Tired	▢ Unmotivated	▢ Blood Pressure High / Low
▢ Cold Sores	▢ Dizziness	▢ Neck Stiffness	▢ Hip Joint Stiffness
▢ Sinusitis	▢ Jaw Clicking / Pain	▢ Mid Back Pain	

▢ Other (please explain): _____

Is there anything else which may help us to better understand you which has not been discussed?

_____

_____

I consent to a Chiropractic consultation followed by a professional and complete examination if it is deemed that Chiropractic care may help with my issue. I also consent to any radiographic examination and future Chiropractic care moving forward as the Doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me.

Name: _____ **Date:** _____

Signature: _____

Thank you for taking the time to complete this form, it will help us to better serve you!