



PERSONAL DETAILS

All information provided is strictly confidential.
 If you need help with a question please feel free to ask one of our friendly staff.

Title	Surname	Given Names
-------	---------	-------------

Please ensure your name is spelled exactly as per your Medicare card

Address

Suburb	Postcode
--------	----------

HM	WK	MOB
----	----	-----

Email	DOB / /
-------	---------

Health Fund	Does it include Chiropractic Y / N
-------------	------------------------------------

Occupation	Is this a work related injury? Y / N
------------	--------------------------------------

Number of children	Ages
--------------------	------

Who can we thank for referring you to our clinic?

Family or friend	Yellow Pages Book <input type="checkbox"/>	Yellow Pages Online <input type="checkbox"/>	Google / Internet <input type="checkbox"/>	Letter Box Flyer <input type="checkbox"/>	Expo <input type="checkbox"/>
------------------	--	--	--	---	-------------------------------

Doctor or Other Chiropractor	White Pages Book <input type="checkbox"/>	White Pages Online <input type="checkbox"/>	Street Sign <input type="checkbox"/>	Other <input type="checkbox"/>
------------------------------	---	---	--------------------------------------	--------------------------------

Now please turn over

OFFICE USE ONLY

Patient ID	Patient History Codes
------------	-----------------------

Number of images	Xray regions 3 region & pelvis / 2 region & pelvis
------------------	--

GENERAL HEALTH QUESTIONNAIRE

Should your problem require Chiropractic care it is very important we know your general health.

What is your main complaint?

Does it radiate / travel? If so, to where?

How did this occur?

How long have you been having this problem?

Have you had it before / How long ago?

Is it reoccurring / intermittent?

When is it worse / what aggravates it?

When is it better / what relieves it?

Any other complaints?

Have you had Chiropractic care before. If so, how long ago?

Please tick where applicable

Heart Lungs		Neurological		Digestion		Reproductive / Urinary	
Transient ischemic attack	<input type="checkbox"/> 310	Headaches	<input type="checkbox"/> 350	Indigestion	<input type="checkbox"/> 335	Infertility	<input type="checkbox"/> 340
Stroke	<input type="checkbox"/> 311	Migraines	<input type="checkbox"/> 351	Reflux	<input type="checkbox"/> 336	Menstrual problems	<input type="checkbox"/> 341
Heart attacks	<input type="checkbox"/> 312	Dizziness / fainting	<input type="checkbox"/> 352	Ulcer	<input type="checkbox"/> 334	Menopausal	<input type="checkbox"/> 342
Chest pains	<input type="checkbox"/> 313	Nausea	<input type="checkbox"/> 353	Irritable bowel	<input type="checkbox"/> 333	Kidney stones	<input type="checkbox"/> 349
Irregular heart beat	<input type="checkbox"/> 318	Blurred vision	<input type="checkbox"/> 354	Bleeding bowel	<input type="checkbox"/> 332	Prostate	<input type="checkbox"/> 343
High blood pressure	<input type="checkbox"/> 316	Numbness (arm/hip/leg)	<input type="checkbox"/> 355	Diverticulitis	<input type="checkbox"/> 331	Impotence	<input type="checkbox"/> 344
Low blood pressure	<input type="checkbox"/> 317	Convulsions	<input type="checkbox"/> 356	Gall bladder	<input type="checkbox"/> 330	Urinary pain	<input type="checkbox"/> 345
Breathing problems	<input type="checkbox"/> 314			Constipation	<input type="checkbox"/> 337	Urinary control	<input type="checkbox"/> 346
Asthma	<input type="checkbox"/> 315			Diarrhoea	<input type="checkbox"/> 338	Urinary frequency	<input type="checkbox"/> 347
						Kidney/bladder infections	<input type="checkbox"/> 348
Immune system / allergies		General Health (please rate from 1 to 5)		Lower limb		Past Injuries (major or minor, anytime from childhood)	
Sinus	<input type="checkbox"/> 326	Diet	<input type="checkbox"/> 370	Knee arthritis / pain	<input type="checkbox"/> 390	Sporting history	<input type="checkbox"/> 300
Recurrent colds / flu	<input type="checkbox"/> 325	Fitness / flexibility	<input type="checkbox"/> 371	Foot arthritis / pain	<input type="checkbox"/> 395	Falls / impacts	<input type="checkbox"/> 303
Hay fever	<input type="checkbox"/> 324	Emotional wellbeing	<input type="checkbox"/> 372	Sole / metatarsal pain	<input type="checkbox"/> 391	Motor vehoical accident	<input type="checkbox"/> 301
Urinary tract	<input type="checkbox"/> 323	Posture	<input type="checkbox"/> 373	Arch pain	<input type="checkbox"/> 392	Heavy bending / lifting	<input type="checkbox"/> 302
Skin	<input type="checkbox"/> 322	Energy levels	<input type="checkbox"/> 374	Heel pain	<input type="checkbox"/> 393	Poor posture	<input type="checkbox"/> 304
Food allergies	<input type="checkbox"/> 321	Current medications	<input type="checkbox"/>	Shin splints / pain	<input type="checkbox"/> 394	Physical work	<input type="checkbox"/> 305
Other allergies/infections	<input type="checkbox"/> 320			Bunions	<input type="checkbox"/> 396		

Signature:

Date: