CASUARINA CHIROPRACTIC

Reset Form

Confidential Patient Information

Full Name Date

Address

Postcode

Telephone H W M

Best time/place to contact you

Email

Date of birth Age

Spouse/guardian name

No. of children Pregnant? Yes ☐ No ☐

Your Occupation

Who may we thank for referring you?

Shop 14, 480 Casuarina Way, Casuarina. NSW 2487 0498 012 334

www.casuarinachiropractic.com.au hello@casuarinachiropractic.com.au

Why have you come to see us?

Since the problem started is it... About the same ☐ Getting better ☐ Getting worse ☐

Do you have pain from the above? Yes ☐ No ☐

Is your pain... dull ☐ sharp ☐ achy ☐ numbness or tingling ☐ burning ☐

Does it radiate anywhere? If so, where?

When is it worst/what aggravates it?

When is it better/what relieves it?

When did this happen?

Has it happened before? When?

Did the problem start with an injury? Yes ☐ No ☐

% of the time the pain is present:

Is this condition interfering with any of the following?

Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Household duties ☐

Relationships ☐ Other (please explain)

How would you grade your current level of health? (very poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

Where do you ultimately need your health to be? (very poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

What importance do you place on your health & wellbeing? (none) 1 2 3 4 5 6 7 8 9 10 (most)

Vital health profile

Please tick the following conditions which are relevant to your health history:

- ☐ Neck pain
- ☐ Headaches
- ☐ Migraines
- ☐ Low energy
- ☐ Dizzyness
- ☐ Allergies
- ☐ Numbness/Tingling
- ☐ Sinus problems
- ☐ Visual disturbances
- ☐ Depression
- ☐ Anxiety
- ☐ Ringing in ears
- ☐ Epilepsy
- ☐ Sleeping difficulties
- ☐ Mid back pain
- ☐ Breathing difficulties
- ☐ Asthma
- ☐ Chest pains
- ☐ Recurrent colds/flu
- ☐ Heart attack
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Back pain
- ☐ Digestive complaints
- ☐ Bowel problems
- ☐ Menstrual cramps
- ☐ Irregular periods
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Eczema
- ☐ Thyroid problems
- ☐ Multiple Sclerosis
- ☐ Ear infections

Other (please explain)

General Health History

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

Have you had accidents and/or injuries; car, work-related, sports, horse riding, falls, minor car accidents, or other?

Hospitalised?

1. Type _____ When? _____ Yes ☐ No ☐
2. Type _____ When? _____ Yes ☐ No ☐
3. Type _____ When? _____ Yes ☐ No ☐

Have you ever been hospitalised? (Please include all surgery)

1. Why _____ When? _____ Where _____
1. Why _____ When? _____ Where _____

Have you ever had any x-rays, C/T, MRI, other advanced imaging taken?

Area of body _____ When? _____
Area of body _____ When? _____
Area of body _____ When? _____

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why:
(prescription and non prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Previous Care

Chiropractor ☐ GP ☐ Orthopedic Surgeon ☐ Specialist ☐
Physio ☐ Osteopath ☐ Massage Therapist ☐ Medication ☐
Other _____

Previous Chiropractor's Details

Name _____ Town/City _____
When did you see them? _____
Did it help? _____

Medical Doctor's Details (G.P.)

Name _____
Town/City _____
When did you last see them? _____

Stressors

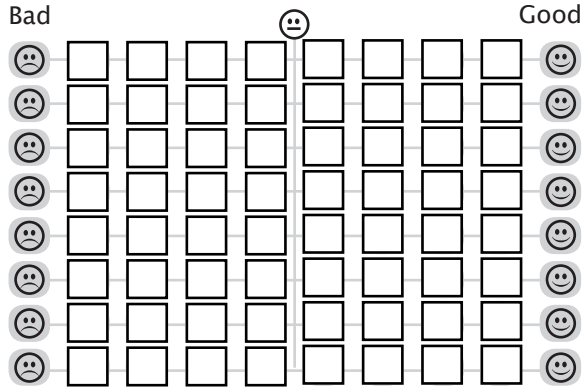
Stress affects our health and ability to heal. Please list the top three stressors you have ever had in each category.

Physical Stress (falls, accidents, work postures, sports, MVA, repetitive activities, etc)

Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, medications, flavoured fizzy drinks, work with chemicals etc)

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, anxiety, depression etc)

Please rate your current aspects of life



- Stress at work
- Stress at home
- Time relaxing
- Eating Habits
- Exercise Habits
- Sleep
- General Health
- General frame of mind

Is there anything else which may help us to understand how you're feeling?

What is the main goal you hope to achieve from chiropractic care?

(wellness, performance, healthier, pain relief, etc)

If you could improve any other areas of your life, which of these would they be?

- ☐ Energy levels
- ☐ Quality of Sleep
- ☐ Immunity
- ☐ Headaches
- ☐ Flexibility
- ☐ Daily activities
- ☐ Quality of life
- ☐ Stiffness
- ☐ Happier
- ☐ Digestion
- ☐ Bowel function
- ☐ Pain
- ☐ Bladder function
- ☐ Muscle strength
- ☐ Ringing in ears
- ☐ Muscle tension
- ☐ Numbness & Tingling
- ☐ Better balance
- ☐ Fatigue
- ☐ Breathing
- ☐ Allergies
- ☐ Asthma
- ☐ Athletic performance
- ☐ Response to stress
- ☐ Mental creativity
- ☐ Concentration
- ☐ Hormone balance

☐ I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for services is due at the time of my visit.

Print your Name

Date

Signature