PERSONAL HEALTH HISTORY

Date:_____/_____/_____

Title: Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Full Name:_____ Preferred Name:_____

D.O.B____/_____/_____ **Age:**_____ **I am a:** Pensioner ☐ **Full-time** Student ☐ Concession ☐

Address: _____

Phone (H)_____(W)_____(M)_____

Email:_____

Occupation:_____ **Employer:**_____

Spouse/Partner Name:_____

Children & Age(s):_____

Previous Chiropractic Care: (Doctor & when):_____

I have been referred to this clinic by Mr/Mrs/Miss:_____

Family ☐ Friend ☐ Sign ☐ Yellow pages ☐ website ☐ Other: ☐ please specify: _____

Emergency Contact: _____**Phone:**_____

CURRENT HEALTH CONDITION

Present problem/reason for your visit today (be brief):

Please list your health issues/pains starting with your most severe	How bad is it 1=Mild 10=Worst	When did this episode start?	If you have had this condition before, when?	Did the problem begin with an injury?

Major complaint is: **Sharp** ☐ **Dull** ☐ **Constant** ☐ **Intermittent** ☐

What activities aggravate your condition? _____

What activities lessen your condition?_____

Is your condition worse during certain times of the day? _____

Is this condition interfering with: Work ☐ Sleep ☐ Routine ☐ Other?_____

Is this condition progressively getting worse? Yes ☐ No ☐

Who else have you seen for this condition? Chiropractor ☐ G.P. ☐ Physio ☐ Other:_____

Home remedies: _____

How is your lifestyle affected by this condition? (e.g. Fatigue, can't sleep, trouble gardening, etc) _____

_____

Other issues:_____

Who is your medical doctor?_____

Are you currently under drug/medical care?_____

If so, for what condition? _____

Current Medication(s):_____How long for?_____

Are you interested in: A quick fix? ☐ A lifestyle wellness program? ☐

HEALTH CONCERNS

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

Have you had any surgery? (please include all surgery)

Type	When	Doctor

Accidents and/or injuries: auto, work-related, other? (Especially those related to your current problems)

Type	When?	Hospitalised?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Stressors: Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

Physical stress (falls, accidents, work postures etc)

_____

_____

_____

Bio-chemical stress (smoke, unhealthy foods, missed meals, too little water, drugs/alcohol etc)

_____

_____

_____

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

_____

_____

_____

On a scale of 1-10 (1 = very low & 10 = extremely high) please grade your present levels of stress (including Physical, bio-chemical and psychological or mental/emotional)

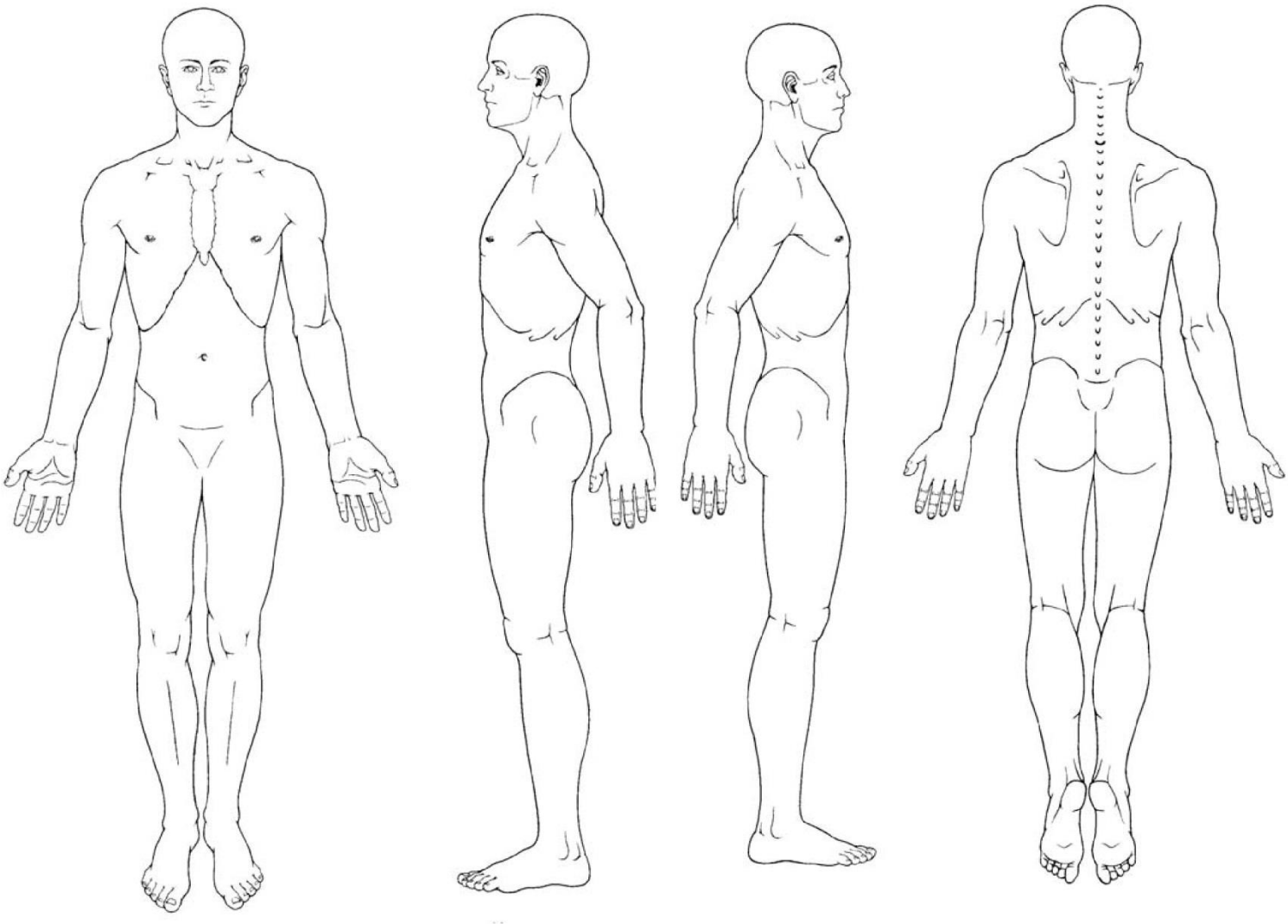
At work:	At home:	At play:

Other Current symptoms (please tick the appropriate answers)

☐ Headaches	☐ Low back discomfort	☐ Fainting	☐ Ears ring
☐ Neck discomfort	☐ Constipation	☐ Light bothers eyes	☐ Loss of smell
☐ Pins & needles in arms	☐ Diarrhoea	☐ Shortness of breath	☐ Loss of taste
☐ Pins & needles in legs	☐ Stomach upset	☐ Cold hands	☐ Fever
☐ Numbness in toes	☐ Tension	☐ Cold Feet	☐ Cold sweats
☐ Numbness in fingers	☐ Nervousness	☐ Low BP	☐ Buzzing in ears
☐ Loss of balance	☐ Fatigue	☐ High BP	☐ Anxiety
☐ Dizziness	☐ Irritability	☐ Loss of memory	☐ Depression
☐ Sleeping problems	☐ Chest pains	☐ Burning feet	☐ Other?_____

Please mark on the diagrams below where you are experiencing difficulties/discomfort.

R FRONT L LEFT SIDE RIGHT SIDE L BACK R



Sleeping Posture: Side ☐ Stomach ☐ Back ☐

Are you interested in learning more about: Stress management ☐ Nutrition ☐ Exercises or stretches ☐

What was the motivating factor in your decision to book this appointment at our clinic? _____
_____
_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the Doctor deems necessary.

Patient Name: _____Signature:_____