**CONFIDENTIAL PATIENT HISTORY**

Name (MR/MRS/MS/MISS) (Full Name) : .....

Address:..... Postcode.....

Telephone: Home ..... Work ..... Mobile ..... Date of birth: .....

Age ..... Male ☐ Female ☐ (Married ☐ Single ☐ Divorced ☐ Widowed ☐ De facto ☐ Separated ☐ ) **(optional)**

Employer:..... Occupation: .....

Sport/ Hobbies:..... Allergies: .....

Medical Doctor:..... Name of Health Insurer: .....

Spouse/Partner/Parents name: ..... Medicare no. _____ _____ Ref no_ Exp date:____ / _____

Recommended / Referred by:..... Email: .....

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Have you been to a Chiropractor before? Yes / No If Yes, who? …….. Date of last visit:.....

Have you had X-rays taken before of your Spine? Yes / No If Yes, when?.....Do you have access to it? Yes / No

**What is your major complaint / problem?** .....

When did it occur? ..... Did you experience this problems before?..... , if so how long ago?.....

Is this a work related injury? Yes / No Is this related to a vehicle accident? Yes/ No

List any treatments given / or previous diagnosis made for present complaint .....

Have you **ever** been involved in any other accidents, (eg. fell out of a tree , or sport injuries, vehicle accident)? Yes / No

Give details .....When? .....

Any other complaints / Problems?.....

Details of any Surgery? ..... When?.....

Drugs you currently taken: Nerve Pills ☐ Pain Killers ☐ Anti-Inflammatory ☐ Tranquilizers ☐

Blood Pressure ☐ Birth Control Pills ☐ Anti-coagulation ☐ Dietary supplements ☐

Others .....

How often do you go to the Dentist: 6 months ☐ 12 months ☐ Emergency ☐ Complete dentures ☐

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Do you, or have you, suffered from any of the following? — Tick & circle (if more than 1 option) If Yes.

GENERAL
-- Anemia
--AIDS/HIV
--Cancer
--Diabetes
--Epilepsy / Convulsions
--Fainting / Loss of consciousness
--Fatigue / Dizziness
--Headache
--Hepatitis A / B / C
--Nervousness / Depression
--Rheumatic Fever
--Psoriasis / Other skin diseases
--Stroke / Tremors
--Sweats
--Weight loss / gain
--Ross river fever
--any Other Blood diseases

CARDIOVASCULAR
--Chest pains with exercise / angina
--Hardening of Arteries
--High Blood Pressure
--Low Blood Pressure
--Poor circulation / heart disease
--Rapid / irregular heart beat
--Swelling of ankles
--Varicose Veins

EYES, EARS, NOSE & THROAT
-- Deafness
--Ear pain / problems
--Thyroid / Goiters
--Eye pain / Visual disturbance / Double vision
--Nasal obstruction
--Nose bleeds

GENITO/URINARY
--Prostate trouble
--Kidney infections/stones
--Painful / burning urine
--Blood in urine
--Bed wetting
--Frequent urination
--Inability to control bladder

RESPIRATORY
--Sinus / Hayfever
--Chronic cough
--Difficult breathing
--Emphysema
--Wheezing / Asthma
--Tuberculosis

**GASTRO INTESTINAL**
--Colitis
--Distension of Abdomen
--Excessive Hunger / Thirst
--Gall-bladder trouble
--Hernia
--Inability to control bowel
--Liver trouble / Jaundice
--Nausea / Vomiting / indigestion
--Pain over stomach
--Poor appetite
--Vomiting of blood
--Cholesterol

**MUSCLE and JOINT**
--Arthritis
--Disc injury (which one?_____ when happened? _____ )
--Fractures (which part of body? _____when happened? _____ )
--Gout
--Low back pain
--Multiple Sclerosis
--Muscle wasting
--Neck pain or stiffness
--Osteoporosis
--Pain between shoulders
--Sciatica
--Scoliosis

**PLEASE LIST ANY FAMILY MEMBER / RELATIVES THAT SUFFER SPINAL OR OTHER HEREDITARY / FAMILIAL**

**DISEASES: ……**

> **FEMALE PATIENTS ONLY :**

Are you Pregnant? _____ Date: of last menstrual period _____ Painful menstruation?_____
Premenstrual tension? _____ Menopausal symptoms? _____Last breast exam _____

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Current Major complain:

**INTENSITY OF PAIN/SENSATION**
--3 mild
--4 moderate
--5 substantial
--6 severe
--7 very sever
--8 ……

**TYPE OF PAIN/SENSATION**
--aching pain
--dull ache
--sharp pain
--knife-like pain
--stabbing pain
--numbness
--tingling sensation
--pins & needles sensation
--soreness
--stiffness
--loss of strength

**CONDITION AGGREVATED BY**
--sitting
--standing
--walking
--laying / sleep
--coughing
--work
--twisting movement
--nothing specific

**FREQUENCY OF PAIN**
--constant
--comes and goes

**CAUSE OF CURRENT ONSET**
--a fall
--a strain
--lifting
--a Motor vehicle accident
--an industrial injury
--mental stress
--continuation of previous injury

**SIGNATURE OF PATIENT, PARENT OR GUARD _____ DATE _____**