Forest Lakes
CHIROPRACTIC

CHIROPRACTIC: Natures Gift

PATIENT INFORMATION

Given Names:_____ Surname:_____

What do you like to be called?:_____ Sex: M / F

Address:_____ Suburb:_____ Postcode:_____

Date of Birth:_____ Age:_____ Marital Status:_____ No. Children_____

Occupation:_____ Email: _____

Would you like to sign up for our monthly informative newsletter Y / N

Who referred you to this clinic?_____ Health Insurer/Concession:_____

HEALTH HISTORY

Have you ever been to a Chiropractor? Y / N If yes, why?_____

Your reason for this visit?_____

Please describe your current symptoms and their location _____

_____

Using the SCALE below, mark the INTENSITY of the pain/discomfort you're experiencing:

0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

No Pain Severe pain

Are the symptoms getting: ☐ worse ☐ better ☐ the same ☐ comes and goes

When did the symptoms begin?_____

How often do you have this pain?_____

Have you had similar conditions in the past?_____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stiffness ☐ Aching

☐ Throbbing ☐ Burning ☐ Numbness ☐ Cramping ☐ Swelling

Activities that are difficult to perform:

☐ Sitting ☐ Walking ☐ Bending ☐ Lifting ☐ Lying down ☐ Recreation

Female patients: Is there any possibility you may be pregnant? Y / N

Do you smoke cigarettes? Y / N Have you had any rapid recent changes in weight Y / N

Please list any medications you are taking:_____

Please list any car accidents, injuries or impacts you have had:_____

_____

Check off any of the following symptoms you have experienced in the past six months:

☐ Neck pain
☐ Headaches
☐ Ringing in the ears
☐ Dizziness
☐ Allergies
☐ Tension across the top of the shoulders
☐ Pain between the shoulder blades
☐ Numbness/Tingling in arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Low back pain
☐ Tired/Fatigued
☐ Asthma
☐ Difficulty sleeping
☐ Digestive problems
☐ Weight problems

I understand this clinic functions on a cash basis and I am financially obligated for any fees, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain reimbursement from insurance companies. Legal opinion is that X-rays remain property of the clinic, however these will be forwarded to suitably qualified practitioners upon their request.

SIGNATURE _____ DATE _____