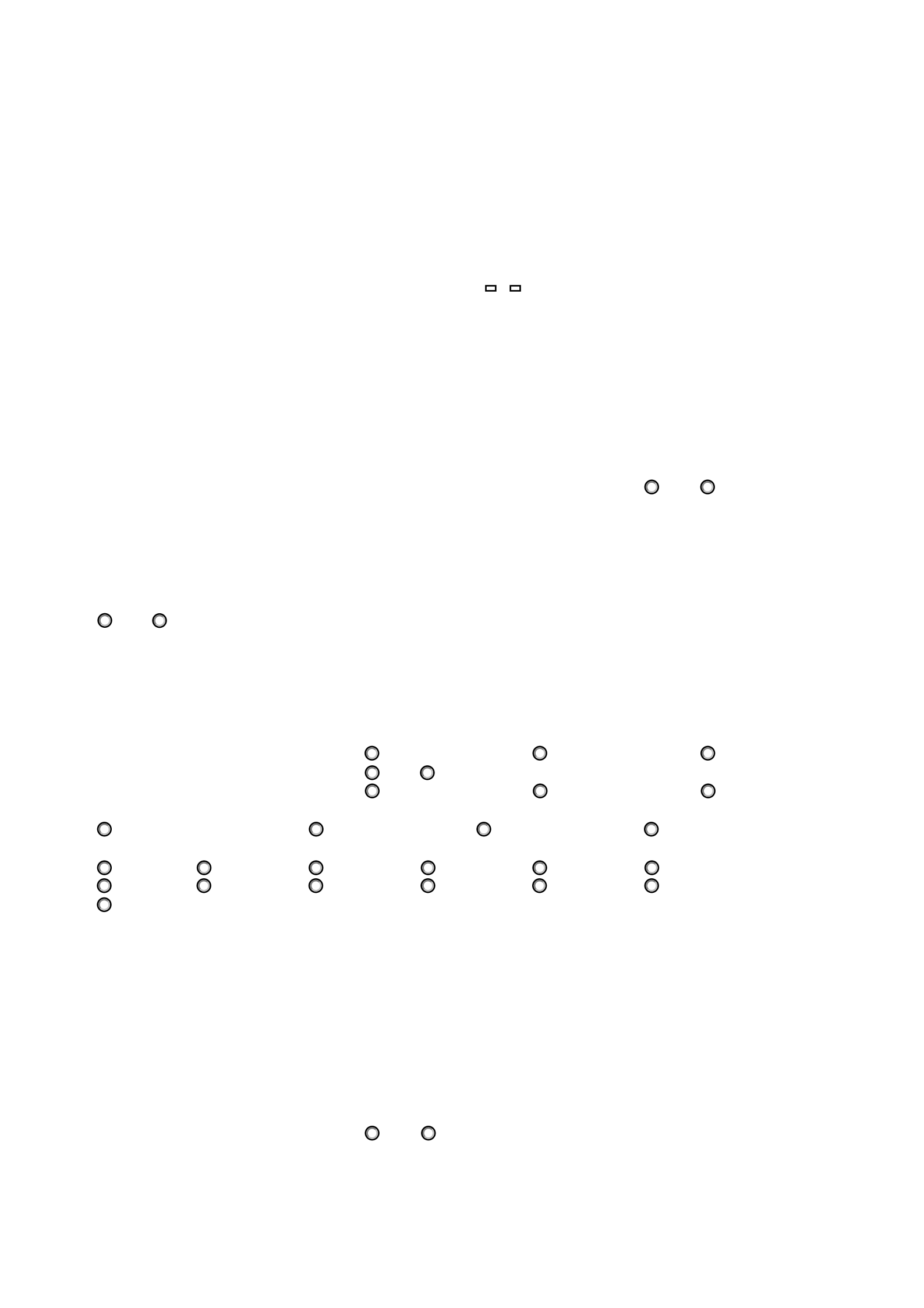

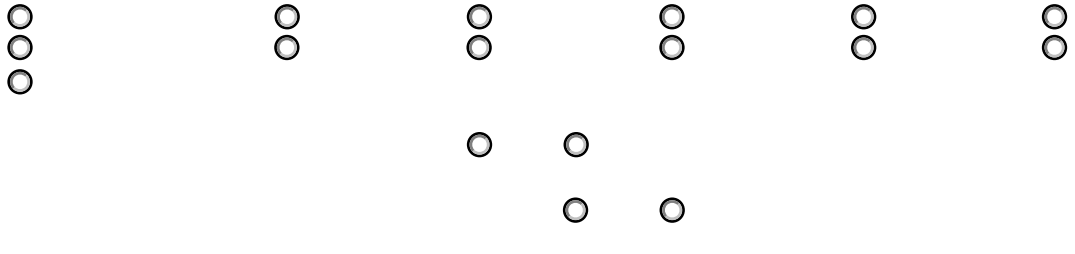

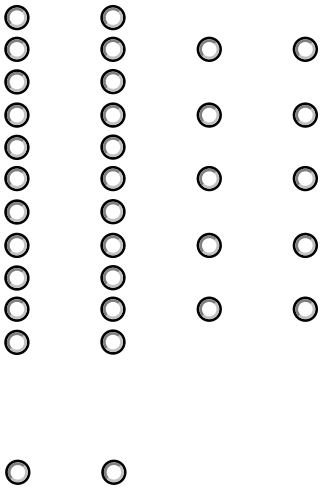

CHIROPRACTIC HISTORY

Have you had previous Chiropractic care? ◯ YES ◯ NO
If Yes, what is the name of your previous Chiropractor? : _____
Where are / were they located? : _____
When was the last visit / treatment? : _____
Were X-Rays taken? ◯ YES ◯ NO
If Yes, when?: ___/___/_____

Was the previous Chiropractor a Gonstead practitioner? ◯ YES ◯ NO ◯ NOT SURE
What were the results of your previous treatment?
◯ Excellent ◯ Satisfactory ◯ Fair ◯ Did Not Help ◯ Got Worse

I declare that the above information is true and correct at the time of completion. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

_____ _____
Patient Name (Printed) Patient Signature

Date: ___/___/_____

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

MUSCULOSKELETAL ◯ Neck Or Back Pain ◯ Hip, Knee, Ankle Or Foot Pain ◯ Shoulder, Elbow, Wrist Or Hand Pain ◯ Swollen Joints ◯ Arthritis ◯ Weakness Or Loss Of Strength	**EYES** ◯ Vision Changes / Blurring / Double Vision ◯ Glasses / Contacts ◯ Dry / Watery ◯ Eye Pain ◯ Redness	**EARS** ◯ Hearing Loss ◯ Tinnitus (Ringing), Buzzing ◯ Vertigo ◯ Pain ◯ Infection ◯ Slurred or other speech problems	**NOSE** ◯ Discharge ◯ Pain ◯ Difficulty Smelling Things ◯ Frequent Colds / Sinusitis ◯ Stuffiness ◯ Hay Fever ◯ Nose Bleeds
NEUROLOGICAL ◯ Loss Of Consciousness / Fainting / Blackouts / Seizures ◯ Sensory Loss / Tingling / Numbness / Weakness ◯ Wasting ◯ Headaches ◯ Memory Problems ◯ Dizziness / Vertigo / Spinning ◯ Tremors ◯ Reduced Coordination ◯ Balance Problems ◯ Head Injury ◯ Lumps Or Swollen Glands	**RESPIRATORY** ◯ Chronic Cough ◯ Chest Pain ◯ Spitting up Phlegm or Blood ◯ Asthma or Wheezing ◯ Difficulty Breathing ◯ Tuberculosis **ENDOCRINE** ◯ Thyroid Problems ◯ Heat / Cold Intolerance ◯ Unexplained Or Weight Gain / Loss ◯ Excessive Thirst	**CARDIOVASCULAR** ◯ Chest Pain ◯ Heart illness / Arrhythmias / egularities ◯ High Blood Pressure ◯ Low Blood Pressure ◯ Blood Disorder ◯ Poor Circulation ◯ Swelling in Limbs ◯ Varicose Veins ◯ Cold Hands / Feet ◯ Stroke ◯ Anaemia	**MOUTH** ◯ Pain ◯ Swelling ◯ Dryness ◯ Toothaches ◯ Bleeding Gums, Tongue / Lips **THROAT** ◯ Infections / Sore Throat ◯ Bad Breath ◯ Difficulty Swallowing ◯ Swollen Glands

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

GASTRO-INTESTINAL	GENITO-URINARY (General)	GENITO-URINARY (Females Only)	SKIN
◯ Poor Appetite / Excessive Hunger	◯ Bed Wetting	◯ Cramps or Back Pain	◯ Eczema
◯ Pain over the Abdomen	◯ Kidney Infections	◯ Painful Menstruation	◯ Psoriasis
◯ Difficulty Swallowing	◯ Frequent Urination	◯ Irregular Menstruation	◯ Lumps / Bumps / Swelling
◯ Nausea	◯ Difficulty Urinating	◯ Absence of Menstruation	◯ Bruise easily
◯ Ulcers	◯ Incontinence	◯ Hot Flashes	◯ Mole Changes
◯ Heartburn / Indigestion	◯ Blood in Urine	◯ Excessive Flow	◯ Rashes and/or Itching
◯ Vomiting (blood?)	◯ Burning with Urination	◯ Vaginal Discharge	◯ Acne
◯ Excess Wind (Belching or Flatulence)	◯ Excessive Urination at night	◯ Swollen Breast	◯ Dryness
◯ Bowel Irregularity (Incontinence?)	◯ Prostate troubles	◯ Lumps in Breasts	◯ Colour changes
◯ Food Intolerance	◯ Discharge	◯ Discharge	◯ Temperature changes
◯ Blood in Stools		◯ Pregnant	
◯ Diarrhoea / Constipation		◯ Difficulty Conceiving	
◯ Haemorrhoids (piles)			
◯ Jaundice / Anaemia			
◯ Chronic Fatigue			

PSYCHOLOGICAL

◯ Stress	◯ Anxiety	◯ Depression
◯ Nervousness	◯ Difficulty Coping	◯ Counselling

OTHER HEALTH PROBLEM:

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