Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible care.

Full Name: _____ Today's Date: _____

Date of Birth: _____ Occupation: _____

Mobile: _____ Home Phone: _____

Email Address: _____

Address: _____

City: _____ State: _____ Postcode: _____

Emergency Name: _____ Emergency Phone: _____

Who referred to you this Chiropractic Office? GP **O** Massage Therapist **O** Podiatrist **O** Google **O**

Signage **O** Relative **O** Word of Mouth **O** Name:_____

Do you have a: Concession card **O** Student card **O** Seniors card **O** DVA card **O**

Reason for Care

Specific Concern **O** Chiropractic Spinal Check-up **O**

Main concern: _____

What do you think caused this problem? _____

_____

How long have you had this problem? _____

Is it… Getting Better **O** Getting Worse **O** Staying the Same **O** On/Off **O**

Rate the severity: Good 0 1 2 3 4 5 6 7 8 9 10 Bad

Describe the nature of your symptoms:

Sharp **O** Ache/Dull **O** Stabbing **O** Burning **O** Throbbing **O**

Shooting **O** Radiating **O** Tightness **O** Stiffness **O** Numbness **O** Tingling **O**

Details: _____

Are you currently OR have you previously (please circle) received treatment for the above symptoms from any other practitioners?

Chiro **O** Physio **O** GP **O** Massage Therapist **O** Naturopath **O** Specialist **O** Other:_____

Length of care (weeks, months etc): _____ Outcome of care: _____

Have you had any X-rays or scans for this complaint? Yes **O** No **O**

Details (date, area, type):_____

Past Health History

Have you had any previous chiropractic care? Yes **O** No **O** If Yes; Reason: _____

Name of previous Chiropractor / Clinic: _____ Date of last visit: _____

Was the previous Chiropractor a Gonstead Chiropractor? Yes **O** No **O** Not Sure **O**

Do you have a regular GP? Name: _____ Clinic: _____

Past Health History (cont)

Please name 3 things you do to better your health

1._____

2._____

3._____

What sort of stressors are you putting on your body on a daily basis? _____

_____

Do you take any medications? If yes, please list: (e.g. blood thinners, pain killers, anti-depressants etc.)

_____

Do you smoke? Yes **O** No **O**

Have you been hospitalised recently? Yes **O** No **O** When: _____

If YES, why: _____

Have you been diagnosed with any of the following?

Cancer **O** Diabetes **O** Stroke **O** Heart Disease **O** Osteoporosis **O** Arthritis **O** Other: _____

Details: _____

Has anyone in your family been diagnosed with any of the following?

Cancer **O** Diabetes **O** Stroke **O** Heart Disease **O** Osteoporosis **O** Arthritis **O** Other: _____

Details (describe who and what type): _____

Cancer **O** Diabetes **O** Stroke **O** Heart Disease **O** Osteoporosis **O** Arthritis **O** Other: _____

List any Surgeries & the year they were performed:

Year	Type of Surgery	Reason

List any major traumas, injuries & falls you have sustained:

Year	Details

Have you ever been in Motor Vehicle Accident? Yes O No O

Year	Details

Although these symptoms may not be related to your condition, they will help us to identify other health issues that might affect your care.

Please circle if you have an ongoing history of any of the following:	
Musculoskeletal	Neck pain; swollen joints; arthritis; scoliosis; sciatica; weakness; loss of strength
General	Allergies; fatigue; fever; skin conditions; weight gain; weight loss
Psychological	Anxiety; depression; stress; difficulty coping; bipolar disorder; other mental health conditions
Nervous System	Dizziness; fainting; numbness; tingling; poor balance; falls; seizures
Head	Headaches; migraines; hearing loss; tinnitus; jaw problems; visual problems; blurred vision
Heart & Circulation	Abnormal heart rhythm; anemia; blood clotting disorders; chest pain; high blood pressure
Lungs & Breathing	Asthma; chronic cough; difficulty breathing; spitting up phlegm/blood ; painful breathing
Abdominal	Abdominal pain; blood in stools/urine; gall bladder problems; kidney problems; liver problems; loss of appetite; irritable bowel; reflux; nausea; vomiting
Reproductive	Endometriosis; PCOS; pregnancy; testicular pain

If you circled any of the above, please provide further information:

_____

_____

_____

Do you have any other health issues or concerns?

_____

_____

_____

_____

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 Adjustments 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 (including where covered by Worksafe and the Transport Accident Commission, even if liability for my claim is denied).

Patient's Name: _____ Today's Date: _____

Patient's Signature: _____
(Parent or legal guardian to sign if patient is under 18)

Chiropractors Signature: _____

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