**MST – patient health questionnaire**

*The information on this form is and will remain strictly confidential*

Please read the following sections carefully and write your answer / tick where appropriate

## PATIENT DETAILS

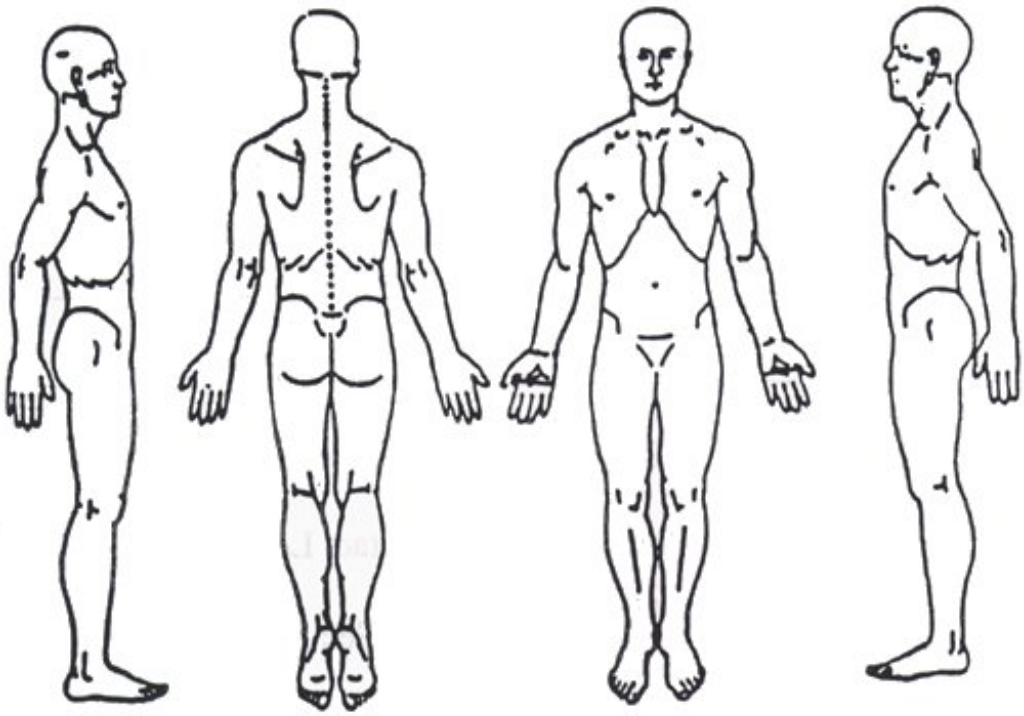
Patient's Name: _____ M / F Date of Birth: __/__/____ Age: _____
Address: _____
City: _____ State: _____ Postcode: _____
Telephone (Home): _____ (Mobile): _____ (Work): _____
Email: _____
Occupation: _____
Marital Status _____ Children (ages) _____
Pregnant or Breast Feeding? ◯ YES ◯ NO

Is your family a member of a Private Health Fund that covers Chiropractic Care? ◯ YES ◯ NO
Name of your Fund: _____

Who referred you to this Chiropractic Office?: Dr / Specialist / Mr / Mrs _____
Have you had previous Musculoskeletal Therapy? ◯ YES ◯ NO
Date of last consultation? __/__/____
Techniques your therapist used: Deep Tissue / Soft Tissue / Myofascial Release / Trigger Point Therapy / Chinese Cupping / Other: _____

## PRESENTING COMPLAINT

Please describe your present complaint and illustrate the affected areas on the diagram: _____



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Are there any other injuries / problems bothering you?_____
Please list any illnesses you have:_____
Please list any drugs, medications or vitamins you take:_____
Have you had any x-rays taken in the past five years? If yes, please detail:_____
Please outline all sporting activities / training habits / hobbies and your level of participation:_____

_____

Please tick the corresponding box if you have suffered from any of the following:

| | | | |
|---|---|---|---|
| ☐ Anaemia | ☐ Diabetes | ☐ Thyroid disease / goitre | ☐ H.I.V. / A.I.D.S |
| ☐ Rheumatic Fever | ☐ T.B. | ☐ Heart Disease | ☐ Paralysis |
| ☐ Asthma | ☐ Eczema | ☐ Stroke | ☐ Kidney Trouble |
| ☐ Cancer / Tumours | ☐ Epilepsy | ☐ Psoriasis | ☐ High Blood Pressure |
| ☐ Hepatitis | ☐ Ulcers | ☐ Nervous Breakdown | ☐ Multiple Sclerosis |

**I declare that the above information is true and correct at the time of completion. I understand that there are minor risks associated with Musculoskeletal Therapy and that these risks are minimised by a thorough examination. 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: ___/___/_____

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