GONSTEAD CHIROPRACTOR
Hoyne Chiropractic . 0424 176 405

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

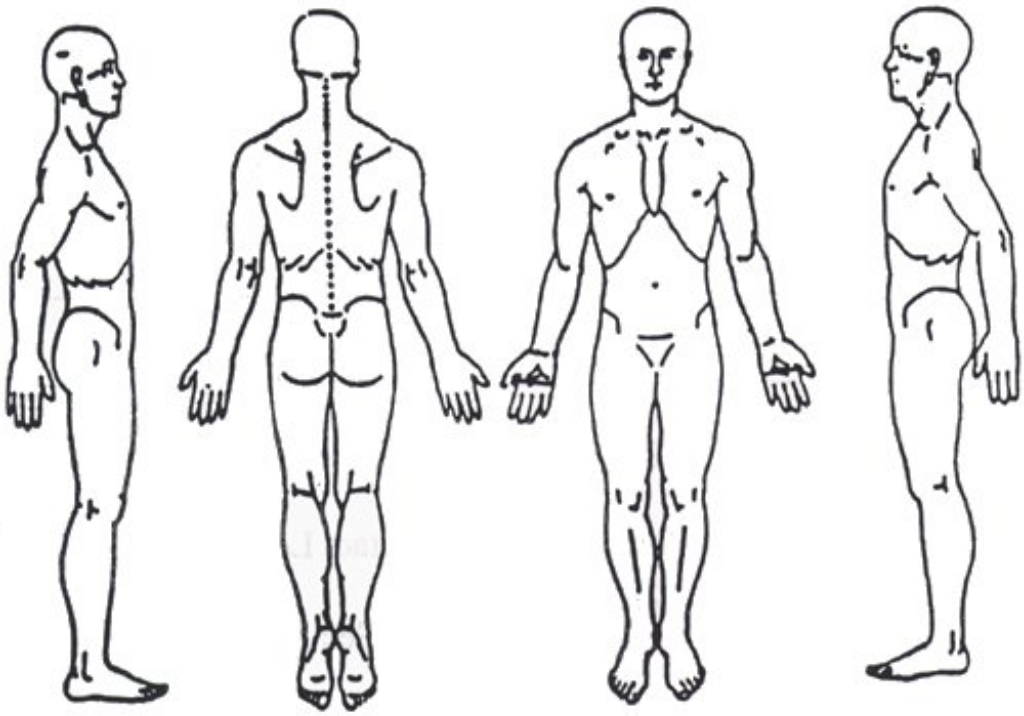
Patient's Name: _____ M / F Date of Birth: __/__/____ Age: _____
Address: _____
City: _____ State: _____ Postcode: _____
Telephone (Home): _____(Mobile): _____(Work): _____
Email: _____
Occupation: _____
Marital Status _____ Children (ages)_____
Pregnant or Breast Feeding? ◯ YES ◯ NO

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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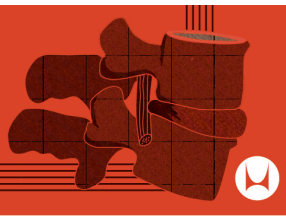

Are there any other injuries / problems bothering you?_____
Please list any illnesses you have:_____
Please list any drugs, medications or vitamins you take:_____
Have you had any x-rays taken in the past five years? If yes, please detail:_____
Please outline all sporting activities / training habits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