PATIENT HISTORY REPORT

PLEASE PRINT

TITLE:_____NAME:_____ DATE:_____

PREFERRED NAME:_____GENDER: **M / F** AGE:_____

BIRTHDATE:_____ HEALTH FUND:_____

ADDRESS:_____ POSTCODE:_____

TEL (H)_____(W)_____(M)_____

EMAIL:_____

OCCUPATION:_____ NO OF CHILDREN:_____ AGES:_____

I HAVE BEEN REFERRED TO THIS CLINIC BY DR/MR/MRS:_____

O FAMILY **O** SIGN **O** PHONE BOOK **O** FRIEND **O** INTERNET **O** HEALTH PRACTIONER

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? **O** YES **O** NO BY DR_____ IN _____

I WOULD LIKE HELP FOR:_____

_____

_____

_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? E.g. SITTING_____

I HAVE FELT THIS WAY FOR: **O** DAYS **O** WEEKS **O** MONTHS **O** YEARS

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? **O** YES **O** NO **O** CONSTANT **O** COMES AND GOES

IS THIS CONDITION INTERFERING WITH YOUR? **O** WORK **O** SLEEP **O** DAILY ROUTINE

O OTHER:_____

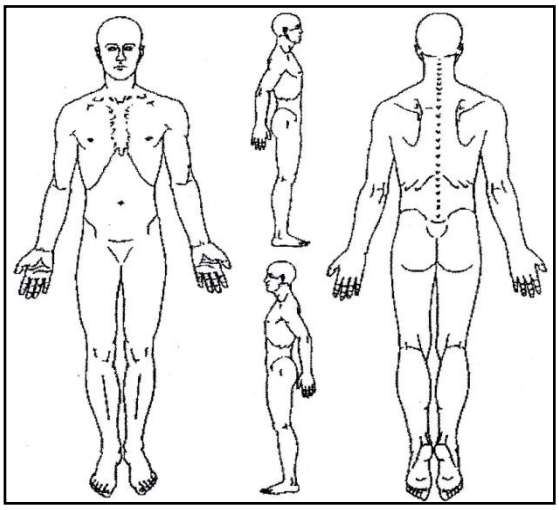
OTHER PROBLEMS I AM CONCERNED ABOUT_____

_____

_____

_____

PLEASE ILLUSTRATE AFFECTED AREAS



HAVE YOU BEEN IN MOTOR VEHICLE ACCIDENTS? YES / NO

WHEN?_____

DESCRIBE:_____

HAVE YOU HAD ANY OTHER PERSONAL INJURIES OR ACCIDENTS?

YES / NO WHEN?_____

DESCRIBE:_____

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD?_____

MY MEDICAL DOCTOR IS DR:_____

OPINION ABOUT MY PRESENT CONDITION WAS:_____

_____

ARE YOU WEARING **O** FOOT SUPPORTS **O** BACK SUPPORT AGE OF MATTRESS:_____

I PLAY THE FOLLOWING SPORTS:_____

_____

I FOLLOW AN EXERCISE PROGRAMME:_____

_____

OPERATIONS AND ILLNESSES I HAVE HAD:_____

_____

_____

_____

_____

MEDICINES, VITAMINS, MINERALS I TAKE/HAVE TAKEN:

_____

_____

_____

_____

DISEASES OR CONDITIONS THAT RUN IN YOUR FAMILY: **O** HEART DISEASE **O** CANCER **O** DIABETES

O ARTHRITIS **O** OTHER_____

I CONFIRM THAT THE DETAILS ABOVE ARE CORRECT AND GIVE CONSENT TO AN EXAMINATION BY THE CHIROPRACTOR

SIGNATURE:_____ DATE:_____