



PATIENT HISTORY REPORT

PLEASE PRINT

TITLE: _____ NAME: _____ DATE: _____

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

HEIGHT: _____ CM WEIGHT: _____ KG 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: _____

- FAMILY
- SIGN
- PHONE BOOK
- FRIEND
- INTERNET
- HEALTH PRACTITIONER

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES NO BY DR _____ IN _____

I WOULD LIKE HELP FOR: _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? E.g. SITTING _____

I HAVE FELT THIS WAY FOR: DAYS WEEKS MONTHS YEARS

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

IS THIS CONDITION INTERFERING WITH YOUR? WORK SLEEP DAILY ROUTINE

OTHER: _____

OTHER PROBLEMS I AM CONCERNED ABOUT _____

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 FOOT SUPPORTS 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: HEART DISEASE CANCER DIABETES

ARTHRITIS OTHER _____

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

SIGNATURE: _____ DATE: _____

PLEASE ILLUSTRATE AFFECTED AREAS

