

# CONFIDENTIAL PATIENT INTRODUCTION

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Health Fund \_\_\_\_\_ Occupation \_\_\_\_\_

Telephone: Res \_\_\_\_\_ Bus \_\_\_\_\_ Mobile \_\_\_\_\_

Marital Status \_\_\_\_\_ Children's names & ages \_\_\_\_\_

Which one of our patients referred you: \_\_\_\_\_

Major Complaint \_\_\_\_\_

Other Complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Is it getting; Worse \_\_\_\_\_ Constant \_\_\_\_\_ Comes/Goes \_\_\_\_\_ Better \_\_\_\_\_

Previous diagnosis and treatment for present condition \_\_\_\_\_

List surgery, accidents, falls \_\_\_\_\_

Are you on any medication? \_\_\_\_\_ Aspirin/Panadol etc \_\_\_\_\_

Have you ever had previous Chiropractic care? \_\_\_\_\_ When? \_\_\_\_\_ Who? \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Address \_\_\_\_\_

**FAMILY HEALTH INFORMATION:** Many health problems are the result of hereditary spinal weaknesses. This information about your family members will give us a better picture of your total health. Please list any member of your family who has had any kind of health problem.

Name	Relation	Past and Present Health Problems

What sports activities/exercises do you perform on a regular basis? \_\_\_\_\_  
 \_\_\_\_\_ How often? \_\_\_\_\_

**NUTRITIONAL:**

Meals Skipped	Coffee - Daily	Alcoholic Beverages	Do you smoke?	Personal satisfaction with diet
Daily No. _____	<input type="checkbox"/> 1-2	<input type="checkbox"/> 1-2 Daily <input type="checkbox"/> 1-2 Weekly	How many	<input type="checkbox"/> Highly satisfied
Weekly No. _____	<input type="checkbox"/> 3-4	<input type="checkbox"/> 3-4 <input type="checkbox"/> 3-4 Weekly	per day? _____	<input type="checkbox"/> Satisfied
	<input type="checkbox"/> More	<input type="checkbox"/> More		<input type="checkbox"/> Unsatisfied
				<input type="checkbox"/> Highly unsatisfied

**PSYCHOSOCIAL:** Have any of the following occurred recently?

<input type="checkbox"/> Depression	<input type="checkbox"/> Divorce	<input type="checkbox"/> Drugs/Alcohol Increase	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Death	<input type="checkbox"/> Change in job status	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Family Problems
<input type="checkbox"/> Increased Work Stress	<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Economic Stress	<input type="checkbox"/> Other: _____

**PLEASE TURN OVER**

**CHECK THE CONDITIONS FOR WHICH YOU HAVE BEEN TREATED**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Thyroid         | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Anaemia                    | <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Mumps            |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Eczema           |
| <input type="checkbox"/> Measles             | <input type="checkbox"/> Polio                      | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Multiple Sclerosis         | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Cold Sores          | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Glandular Fever | <input type="checkbox"/> Allergies        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Infertility      |

**HAVE YOU EVER:**

	Yes	No
Been knocked unconscious	_____	_____
Used a cane, crutch or other support	_____	_____
Been treated for spine or nerve disorder	_____	_____
Had a fractured bone/broken bone	_____	_____
Been hospitalized	_____	_____

**DATE OF LAST:**

Spinal examination \_\_\_\_\_

Physical examination \_\_\_\_\_

Blood Test \_\_\_\_\_

Chest X-ray \_\_\_\_\_

Spinal X-ray \_\_\_\_\_

Dental X-ray \_\_\_\_\_

Urine Test \_\_\_\_\_

**FOR WOMEN ONLY:** When did your last period start? \_\_\_\_\_ Are you pregnant? Yes No Maybe

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment to this clinic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date