Back into Health Chiropractic

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Doncaster East 3109
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Date: _____/_____/__________

The purpose of our clinic is to relieve pain, restore health and improve the quality of life in each patient we accept for care. For us to properly understand your health problem we need a complete history of your present symptoms (should you have any.) We also need information about your general overall health. This in-depth knowledge will help us determine the type of care needed and give some indication as to what can be anticipated in your case. Please answer every question completely and to the best of your ability. By doing so, we will not have to ask you a lot of questions about health problems that do not relate to your case. If, after consultation and/or examination, we do not sincerely believe you will benefit from Chiropractic care, then we will find the right professional for you. Thank you for your cooperation in completing this form.

Personal Information

Title: (Please circle) Mr / Mrs/ Ms/ Miss/ Mst/ Dr. ____________________

Name ____________________

Address ____________________ City____________________

Post Code ____________________ Telephone (Res) ____________________

(Bus) ____________________ (Mobile) ____________________

Email ____________________

Date of Birth ____________________ Age ____________________

Occupation ____________________

Employer ____________________

Health Fund ____________________ Marital Status ____________________

Spouse Name ____________________

Children's names and ages ____________________

Which one of our patients referred you?____________________

Is this injury work related? Yes /No Is this an insurance claim? Yes /No

Is this a general check up? Yes /No

Previous and Current Health

Major Complaint____________________

Other Complaints ____________________

How long have you had this condition?____________________

Is it getting; Worse? ☐ Constant? ☐ Comes/Goes? ☐ Getting Better? ☐

What makes the symptoms better?____________________

Have you consulted anyone about your problem? Yes / No Who:

What was the diagnosis?____________________

What was the treatment given? ____________________

Have you ever had these symptoms before? Yes/ No

What caused them then? ____________________

Have you ever had a serious health problem? Yes/ No

If Yes please describe ____________________

Have you ever had any surgery? Yes /No

Please list ____________________

Have you ever had any accidents (IE MVAs or falls) Yes /No

Please specify ____________________

Have you ever seen a chiropractor before? ____________________

Who?____________________

Where? ____________________

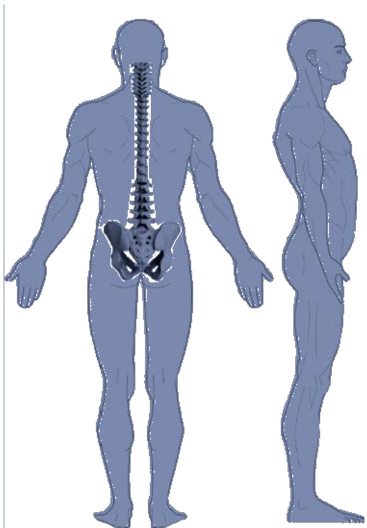
When was your last visit? ____________________

How often were you attending?____________________

How did you find the results? (Please circle)____________________

Excellent / good / fair / poor / no change / felt worse

If yes please list ____________________



Were X-rays taken? Yes / No
When? ______________________________
Have you been taking drugs or medication? (Please circle)

Anti-inflammatory Muscle Relaxants
Pain-Killers Anti-Depressants
Birth Control Pill

Please list all other medications______________________
____
____

Are you taking any supplements (vitamins/minerals) Yes /No
If yes, what? ______________________________
How long has it been since you felt really well?
____
____
____

Pain scale (least Pain) 1 2 3 4 5 6 7 8 9 10 (Worse)

Please mark the following symptoms/conditions:
(**O**) - occasionally (**F**)- frequently(**C**)- constantly (**N**)- never

____Convulsion/Epilepsy
____Low/High Blood Pressure
____Diarrhea/ Loose bowel
____Shortness of breath/ Asthma
____Sudden Loss of Weight
____Sweat Excessively/ Dry Skin
____Sexual Difficulties
____Painful tail bone/ Coccyx
____Loss of Concentration
____Constipation
____Urinary Problems
____Fatigue
____Nausea
____Heel pain
____Sciatica
____Restless Legs
____Dizziness
____Recurring Infections
____Headaches
____Bursitis
____Neck pain or stiffness
____Bladder Weakness
____Nervousness
____Indigestion
____Cramping
____Joint stiffness
____Low Back Pain
____Sleeping Problems
____Bloatedness
____Loss of Balance
____Kidney Infection
____Depression

Females Only

____Painful or tender breasts
____Bleeding between periods
____Endometriosis
____Period Pain
____Infertility
____Difficulty falling pregnant
____Excessive Menstrual Flow
____Menopausal Problems

Are you pregnant? Yes /No
Have you ever; been knocked unconscious? Yes/ No
Had a fractured/broken bone? Yes /No
Used a cane or other support? Yes /No
Been treated for a spine or nerve disorder? Yes /No
Been Hospitalized? Yes /No

Family History

Is there a family history of the following conditions in your family? (Please circle)
Heart Disease Arthritis Stroke Cancer Diabetes Back problems Allergies
Other; ______________________________

I, the undersigned, understand that all fees are payable at the time of consultation, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain re-imbursement from insuring companies. Legal opinion is that X-rays remain the property of the clinic; however these will be forwarded to suitably qualified practitioners upon request.

This form was filled out by____________________________on the request of____________________________________