



**Confidential Patient Case History**

Patient's Name

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you and devise the most effective treatment plan. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

NAME \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 EMAIL ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M  F  Marital Status \_\_\_\_\_ No. of Children \_\_\_\_\_  
 Your Occupation \_\_\_\_\_  
 Who may we thank for recommending you to our clinic? \_\_\_\_\_

**Health Concerns**

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	What caused the problem?	% of time this condition affects you?
1.					
2.					
3.					
4.					

Since the problem started is it: About the same?  Getting better?  Getting worse?   
 How long has it been since you felt really good? \_\_\_\_\_  
 What have you done for this condition, was it of benefit? \_\_\_\_\_

Is this condition interfering with any of the following (please tick):

Work  Sleep  Daily routine  Sports/exercise  Social/family  Other

**Current Medicines and Supplements**

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)  
 \_\_\_\_\_  
 Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:  
 \_\_\_\_\_

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes  No

HAVE YOU EVER	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident or major fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had chiropractic care before?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Name of practitioner _____			
Date of last chiropractic care _____			
Name of G.P. _____			
Date of last G.P. visit _____			

Are you suffering from stress?	0 _____ 10	None _____ Extreme
Do you have a healthy diet?	0 _____ 10	Terrible _____ Excellent
How would you rate your energy level?	0 _____ 10	No energy _____ Full of energy
How committed are you to achieving optimal health?	0 _____ 10	No commitment _____ Total commitment

**Stressors**

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_

**Family Health Information:**

(Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture). Has anyone in your immediate family (including Uncles, Aunts and Grandparents) had any of the following?

- Heart diseases   
  Arthritis   
  Thyroid disease (Goitre)   
  Diabetes   
  Cancer  
 Any other condition \_\_\_\_\_

**Past Health History**

Please mark the following conditions you may have had or have now (—have had, +have now):

- |   |  |   |  |  |   |
|---|--|---|--|--|---|
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Fainting                            | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Headaches/<br>Migraines   | <input type="checkbox"/> Loss of Sleep                 | <input type="checkbox"/> Loss of Weight         |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Stress Related<br>Illness           | <input type="checkbox"/> Nervous<br>Breakdown | <input type="checkbox"/> Other Mental<br>Disorders | <input type="checkbox"/> Freq./Recurrent<br>Infections | <input type="checkbox"/> Lower back<br>pain     |
| <input type="checkbox"/> Neck Pain                | <input type="checkbox"/> Difficult<br>Digestion              | <input type="checkbox"/> Bloating/Gas         | <input type="checkbox"/> Diarrhoea                 | <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Nausea                 |
| <input type="checkbox"/> Pain over<br>stomach     | <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Ringing in<br>Ears   | <input type="checkbox"/> Skin<br>Conditions        | <input type="checkbox"/> High Blood<br>Pressure        | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Difficulty<br>Conceiving | <input type="checkbox"/> Difficulty<br>Carrying<br>Pregnancy | <input type="checkbox"/> Irregular<br>Periods | <input type="checkbox"/> Painful<br>Periods        | <input type="checkbox"/> Lumps in<br>Breast            | <input type="checkbox"/> Menopausal<br>symptoms |

Other (please explain) \_\_\_\_\_

Do you use birth control? If yes, how long? \_\_\_\_\_

Is there any chance you may be pregnant?  Yes  No

Is there anything else which may help to better understand you which has not been discussed? \_\_\_\_\_

What outcomes would you like to achieve from attending our clinic? \_\_\_\_\_

Why are you here at this point in time? \_\_\_\_\_

**IN CASE OF EMERGENCY, PERSON WE CAN CONTACT** \_\_\_\_\_