

chiropractic@thecombo
Confidential Client Information

Please Print Clearly and Complete All Information

Date: _____

Name: Mr / Mrs / Miss / Ms / Dr _____

Address: _____ P/Code: _____

Phone: (H): _____ (M): _____ (W): _____

DOB: _____ Age: _____ Male / Female (please circle) Email: _____

Spouse / Partner's Name: _____ No. of Children: _____ Occupation: _____

Employer: _____ Employer's Address: _____

How did you hear about our office? Who referred you? _____

Have you had Chiropractic Care before? Y / N (circle). If yes, name of chiropractor and date of last visit: _____

Do you have Private Health Insurance? Y / N If Yes, which Insurance Company? _____

Do you have a regular GP? Y / N If yes, what is the name and address of his/her surgery? _____

Have you seen any of the following: (please circle) Physiotherapist, Naturopath, Osteopath, Massase therapist, Myotherapist, Acupuncturist

Other _____

Are you visiting our office for Wellness or a Specific Health Condition? (Please Circle) Please list your Health Condition(s):

1 _____ 2 _____

Original onset date _____ Recent onset date _____

Have you been under any other types of care for your condition? If Yes, What? _____

Has it been of any help? _____

Does anything make it feel better or worse, if so what? _____

Do you have any X-ray, CT scan, MRI or Ultrasound films? Yes / No What type and when were they taken? _____

Accident & Trauma History (Please circle)

Was your birth difficult? Yes / No
Were forceps used in your delivery? Yes / No
Were you a Caesarean birth? Yes / No
Was vacuum extraction used? Yes / No

Please tick the accidents &/or traumas you have had

- Motor Vehicle Accident
 - Car
 - Motorbike
 - Driver
 - Passenger
 - Pedestrian
- Bicycle falls
- Sporting injuries
- Childhood slips or falls
- Falls off ladders and/or stairs
- Horse falls
- Repetitive strain injuries
- Work-related stress (PC, Desk Work)
- Fractures / Dislocations

General Health Questions:

What medical conditions have you had or currently suffering from?

Have you had any previous surgery? _____
Are you taking any medications? Yes / No What kind? What for? (please list)

Are you taking any vitamins/supplements? Y/ N What kind? What for? (please list)

Do you have any ongoing health problems? Yes / No
Are you a smoker? Yes / No
Have you had any unexplained weight loss? Yes / No
Have you had any abnormal bleeding from any body part? Yes / No
Have you had any recent changes to a mole or a freckle? Yes / No
Do you have any unusual lumps or swellings? Yes / No
Has anyone in your family (incl Aunts, Uncles, Grandparents) had any of the following?
 Heart disease _____ Arthritis _____
 Thyroid Disease(Goitre) _____ Diabetes _____
 Cancer

Wellness Questions:

How do you keep fit? (eg, Gym, run, swim etc.) _____
What sports have you played or play? _____
What level do you participate in this/these sport(s)? (eg. Club, A grade, Socially, Casual, For fitness) _____
What do you do to relax/reduce stress? _____
Are you Vegetarian? Yes No

SYSTEMS REVIEW HISTORY

Please tick the appropriate box if you have had or are suffering from the following health conditions. This information will give us a more complete understanding about your body's overall function.

	Constantly/ Frequently	Occasionally/ Sometimes		Constantly/ Frequently	Occasionally/ Sometimes		Constantly/ Frequently	Occasionally/ Sometimes
Neck Pain Stiffness			Stomach problems Indigestion, Heart- burn			Depression		
						Sleeping problems		
Headaches			Difficulty Breathing Asthma			Energy loss		
Migraines						Morning tiredness		
Dizziness			Liver Problems Bloating			Fatigue		
Blurred vision						Fainting feeling		
Ringing/Buzz in ears			Low Back Pain			Frequent Colds		
Hearing Loss			Kidney/Bladder problems			Allergies		
Ear Infections			Colon problems Eg. Irregular Bowel Movements			Skin Conditions		
Sinus problems						Arthritis		
Nose Bleeds			Diabetes			Loss of consciousness		
Mid Back Pain			Female problem			Numbness in any body part		
Chest Pain			Male problems			Weakness in any body part		
Heart trouble			High/Low BP			Cold Limbs		
Palpitations			Stroke			Upper Limb problems		
Difficulty swallowing			Nervousness			Lower Limb problems		

Health Status

Using the 0 – 10 scale below, 10 being Excellent health, please circle what you believe to be your current state of health.

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Very Poor Poor Average Good Excellent

What steps do you think you could take to improve your health and the value above? (For example: More rest, stop smoking/drinking, eating better, etc.) _____

Wellness Commitment

At **chiropractic@thecomom** we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We *do not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

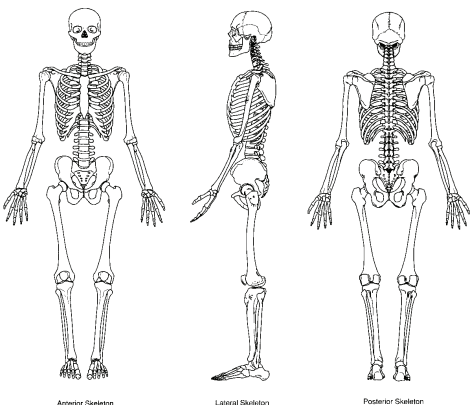
10% — 20% — 30% — 40% — 50% — 60% — 70% — 80% — 90% — 100%

Please note that any and all information, written or otherwise, that you provide is strictly confidential and is so treated by the entire staff. No information or records will be released to any person (health practitioner or otherwise), health fund, or insurance company without the written permission of the patient.

I believe the information above is correct to the best of my knowledge.

Patient's Signature: _____

Date: / /



BWS: L: _____ kg R: _____ kg
Handedness: L R

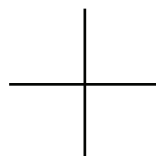
Doctor's Notes

Comments:

ROM:

Cx:

R



Lx:

R

