nervana
CHIROPRACTIC

applecross	8/32 Ardross Street	p9364 5566
kalamunda	7 stirk st	p 9293 2999
kelmscott	6/2684 albany hwy	p 6396 5000
palmyra	61 carrington st	p 9319 2552
warwick	3/8 dugdale st	p 9447 4990
yokine	3/21 wanneroo rd	p 9201 2330

Date:_____/_____/_____ File number_____*(Office use only)*

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 pertain 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 you 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 a Motor Vehicle Case? 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

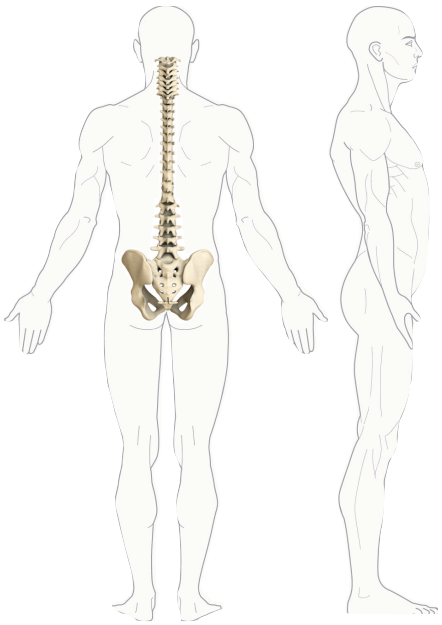
*Please list*_____

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

*Please specify*_____

Please Turn over →

Please mark your areas of pain on the figures below



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

Have you ever seen a chiropractor before? Yes No

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

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

Other- *Please list <u>all</u> medications*_____

_____

Are you taking any supplements (vitamins/minerals) Yes No

If Yes please list_____

How long has it been since you felt really well?_____

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

_____Convulsion/Epilepsy
_____Fatigue
_____Nervousness
_____Low/High Blood Pressure
_____Diarrhea/ Loose bowel
_____Shortness of breath/ Asthma
_____Joint stiffness
_____Indigestion
_____Nausea
_____Sciatica
_____Heel pain
_____Sweat Excessively/ Dry Skin
_____Restless Legs
_____Cramping
_____Sexual Difficulties
_____Loss of Concentration

_____Loss of Balance
_____Dizziness
_____Sudden Loss of Weight
_____Depression
_____Sleeping Problems
_____Bloatedness
_____Headaches
_____Bursitis
_____Low Back Pain
_____Painful tail bone/ Coccyx
_____Neck pain or stiffness
_____Kidney Infection
_____Recurring Infections
_____Constipation
_____Urinary Problems
_____Bladder Weakness

Females Only

_____Painful or tender breasts
_____Period Pain
_____Excessive Menstrual Flow
_____Bleeding between periods
_____Difficulty falling pregnant
_____Menopausal Problems
_____Endometriosis
_____Infertility
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 Hospitalised? 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-embursement 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_____

Signature: _____