Date: _____ / ____ / _____

CORE Chiropractic Centre

PERSONAL INFORMATION

Title: *(Please circle)* Mr / Mrs/ Ms/ Miss/ Mast/ Dr.

Full Name: _____ Date of Birth: _____

Preferred Name: _____ Age: _____

Address: _____

Suburb: _____ Post Code: _____

Phone (H): _____ (Mob): _____

Email: _____ ☐ Please tick if you do NOT want to receive newsletters, seminars info or special offers.

Occupation: _____ Marital Status: _____ Spouse's Name: _____

Number of Children: _____ Names & Ages: _____

Private Health Fund: _____ Covered for chiropractic? _____

Who may we thank for referring you? /How did you find us? _____

Is this injury; Work related? Yes / No A Motor Vehicle Case? Yes / No A general check-up? Yes / No

CURRENT HEALTH

What brings you in today? _____

When did this start? _____

What caused it? _____

Have you had this before? When? _____

Please tick the words that best describe your symptoms:

☐ Sharp Pain	☐ Dull Achy	☐ Stabbing	☐ Throbbing	☐ Stiffness	☐ Cramping
☐ Burning	☐ Swelling	☐ Tingling	☐ Radiates	☐ Numbness	☐ Pins + Needles
☐ Getting Worse	☐ Constant	☐ Comes & Goes	☐ Getting Better	☐ Other _____	

On a scale of **1 – 10**, (where 10 is the worst) how bad is the condition? Today? ____ /10 At its worst? ____ /10

What activities aggravate you condition? _____

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Sport/Exercise

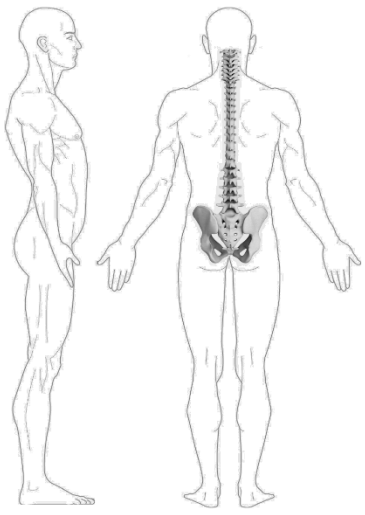
What makes the symptoms better? _____

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

Do you have any other areas of complaint? _____

_____

_____



Please mark on the diagram any areas where you have pain or symptoms

Pain	XXXXXXXX
Numbness	//////////
Pins & Needles	++++++++

Have you had chiropractic care before? ☐ Yes ☐ No

Where? _____ When _____

How often were you attending? _____ Last visit date? _____

Were X-rays taken? ☐ Yes ☐ No

PREVIOUS HEALTH

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 (i.e. MVAs or falls)? ☐ Yes ☐ No

Please specify: _____

Have you ever; ☐ Been Hospitalised ☐ Been knocked unconscious? ☐ Had a fractured/broken bone?

Please specify: _____

Please list any medications / drugs you are taking? *(Please tick)*

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

☐ Other - Please list _____

Any vitamins/minerals/supplements: _____

Please mark the following symptoms/conditions using: ☑ have now ☒ had in the past ☐ never had

☐ Headaches
☐ Migraines
☐ Neck Pain
☐ Mid Back Pain
☐ Lower Back Pain
☐ Hip Joint Pain
☐ Joint Stiffness
☐ Sciatica
☐ Pins & Needles
☐ Numbness
☐ Arthritis
☐ Diarrhoea
☐ Constipation
☐ Indigestion
☐ Bloatedness
☐ Nausea

☐ Fatigue
☐ Sleeping problems
☐ Dizziness
☐ Epilepsy
☐ Nervousness
☐ Loss of Concentration
☐ Loss of Balance
☐ Depression
☐ Hayfever
☐ Low/High Blood Pressure
☐ Asthma
☐ Sexual Difficulties
☐ Restless Legs
☐ Cramping
☐ Urinary Problems
☐ Bladder Weakness

☐ Heart Attack
☐ Stroke
☐ Diabetes
☐ Cancer

Males Only

☐ Prostate trouble

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

FAMILY HISTORY

Is there a family history of the following conditions in your family? *(Please tick)*

☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Diabetes ☐ Allergies ☐ Back Problems

Other: _____

.....

I consent to a professional and complete chiropractic examination. I have completed this form accurately and to the best of my knowledge. I understand that any fee for service is due at the time of service and cannot be deferred to a later date.

Print your name: _____

Signature: _____ Date: _____/ ____ / _____