

The Chiropractic Centre

CONFIDENTIAL PATIENT CASE HISTORY

Name (In full): Mr/Mrs/Miss _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____ Home No.: (____) _____

_____ Work No.: (____) _____

_____ Mobile No.: (____) _____

Post Code: _____ Email: _____

How did you hear about us?

Occupation (Current) _____ Previous) _____

Marital Status: _____ Spouse's name: _____

Children's Details: (please mention any health concerns)

Name: _____ Age: _____ Concerns: _____

Name: _____ Age: _____ Concerns: _____

Name: _____ Age: _____ Concerns: _____

Name: _____ Age: _____ Concerns: _____

GP or surgery name: _____

Do you have private medical insurance? _____

Does it cover Chiropractic: Yes No

Are you making an insurance claim? Yes No

PREVIOUS CARE

Chiropractor Osteopath Physiotherapy Other

If additional space is needed please use the back of this form

Name of Practitioner: _____ Location: _____

Reason for attending: _____

How many visits: _____ How frequent: _____

When did you last attend? _____

What was your response?

Excellent Good Fair Poor No change Worse

Have you had X-rays taken? Yes No

When were they taken? _____ Where were they taken? _____

PRESENT CONDITION

Please describe your present concern or symptom:

Why is it Important to get help? _____

Have you had this before? Yes No If yes, when _____

When did the problem start this time? _____

What, do you feel, caused the condition this time?

Fall Stress Car Accident Strain Lifting Don't know

How have your symptoms changed since their onset?

Getting worse Staying the same Getting better Come and go

Have you consulted anybody else about your current condition? Yes No

If so who? _____ When? _____

Are you currently taking any medication? Yes No

Pain killers Relaxants Nerve pills Birth control

Other (please specify) _____

PREVIOUS, CURRENT AND FAMILY HEALTH

Have you ever had a serious health problem? When? _____

Have you had any operations or been hospitalised for any reason? When? _____

Have you broken any bones or been involved in a major trauma such as a car accident?

Please specify what injuries were sustained and when it occurred. When? _____

Are there any heritable conditions in your family (e.g. heart disease, cancer, arthritis, diabetes?)

Please Tick the boxes that relate to you over the last 6 months.

Occasionally	Frequently	Constantly		Occasionally	Frequently	Constantly	
			Headaches				Palpitations
			Dizziness				High blood pressure
			Blurred Vision				Low blood pressure
			Depression				Heart trouble
			Nervousness				Stomach trouble
			Sleeping problems				Indigestion
			Morning tiredness				Liver problems
			Energy loss				Colon problems
			Ring/buzz in ears				Constipation
			Fainting feeling				Kidney problems
			Sinus problems				Bladder problems
			Allergies				Female problems
			Neck pain				Prostate trouble
			Neck stiffness				Lower back pain
			Shoulder problems				Low back stiffness
			Upper back problems				Hip problem
			Mid back problems				Leg pain
			Chest pains				Tingling

Do you have any other problems that the Doctor should know about?

Would you like?

- Initial intensive care, comfort, relief, temporary patch up?
- Rehabilitation, to help correct the problem with stabilisation?
- Spinal optimization, preventative, wellness care?

DISCLAIMER

I understand that the information, written or otherwise, is given in the strictest confidence. This information will be kept for a minimum of seven years in our records. No information or patient records will be released to any person, health fund, insurance company or other doctor without my written consent. All X-ray films will remain the property of The Chiropractic Centre. I clearly understand and agree that all services are charged to me and I am personally responsible for payment. Fees are due at the time of visit, including X-rays and or examination. I also understand and agree that health, accident, insurance policies are an arrangement between the insurance company and myself, therefore I am personally responsible for any outstanding payment that I am unable to claim through my insurance policy.

I give consent to historical, physical, and X-ray examinations necessary and to provide care by the Chiropractor as they deem appropriate. The practitioner will not be held responsible for any pre-existing medically diagnosed conditions or any medical diagnosis. The statements on this form are accurate to my best recollection

Patient's or parent / Guardian's Signature _____ **Date** _____