ANDERSON FAMILY CHIROPRACTIC Health Centre

Today's Date: _____ Your Occupation: _____

Full Legal Name: _____

D.O.B: _____ Preferred Name: _____

Postal Address: _____

_____ Suburb: _____ Post Code: _____

Home Phone #: _____ Mobile # : _____

Email address: _____

If under 18, please provide your Parent/Guardian's **name** & **mobile**:

Parent/Guardian 1: _____

Parent/Guardian 2: _____

Who to Contact Regarding Appointments: Please Select

Marital Status: Please Select Partner's Name: _____

Children (Names & Ages): _____

Emergency contact Name: _____ Phone: _____

Name & City of previous Chiropractic Centre: _____

Date of last Chiropractic visit: _____

Have you had any Xray/CT/MRIs done of your body? What area of the body was it and where was the imaging performed?

_____

**If you heard about us from a person**, please fill in their name so we can show them our appreciation. If it was not from a person, how did you hear about us?

_____

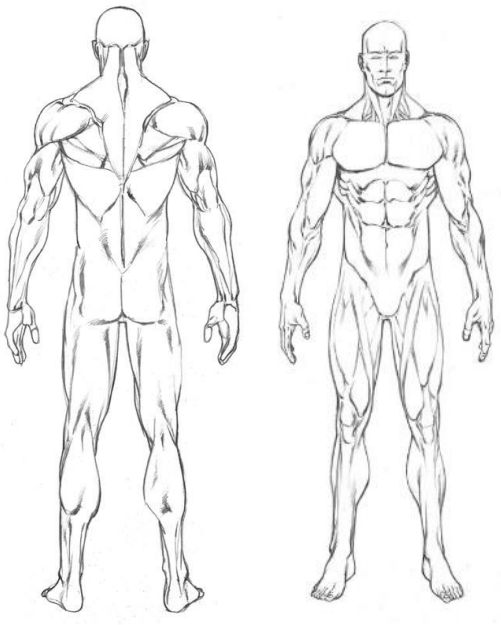
Do you have a government-issued concession card? _____

Are you a member of a heath fund? If so, which one? _____

## Section 1:

Tick this box if you are presenting for wellness/maintenance care **and have no symptoms**. ***Go to Section 2*** ☐

Your Primary Symptom/Complaint:



Any other secondary complaints:

How did your main problem start?

When did you first notice this problem?

What makes this problem feel worse?

What have you tried to help relieve this complaint? Please indicate if you had relief from any of these:

How does this problem interfere with your daily life? For example, unable to sleep, cannot do usual hobbies, can't perform work duties, etc:

What is the pattern of this problem?

◯ Constant ◯ On & Off ◯ Occasional ◯ Cyclical

Does this pain travel to other parts of your body? If so, where?

## Section 2:

***If you wish to list any additional information, use back of page or discuss with the Chiropractor.***

Do you experience any of these conditions?

| | | |
|---|---|---|
| ☐ Sensitivity to light | ☐ Headaches | ☐ Cold feet/hands |
| ☐ Neck discomfort | ☐ Fainting | ☐ Reduced Flexibility |
| ☐ Cancer | ☐ Fatigue | ☐ Pins and needles |
| ☐ Tension | ☐ Chest tightness | ☐ Numbness in legs |
| ☐ Numbness in arms | ☐ Depression | ☐ Addiction |
| ☐ Constipation | ☐ Diarrhoea | ☐ Anxiety |
| ☐ Low blood pressure | ☐ Migraines | ☐ High blood pressure |
| ☐ Heart Disease | ☐ Diabetes | ☐ Loss of balance/dizziness |

Have you suffered from any **major illnesses** or **accidents**? Please list and include **when they occurred** and **if it required hospitalisation**:

_____

_____

Do you currently take any **medications** or **supplements**? Please list them including **dosage** and **purpose**:

_____

_____

Any allergies? _____

Do you smoke/vape? _____ How regularly do you consume alcohol? _____

Do you use recreational drugs? If so, how often? _____

**If applicable to you:**

Date of your last menstrual period? _____

Are you pregnant? _____

Are you using any means of contraception? If so, what form? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____

**Signature of Patient OR Legal Guardian:** _____ **Date:** _____