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:_____

Circle Who to Contact Regarding Appointments: Parent 1 / Parent 2 / Yourself

Marital Status: Single De facto Engaged Married Widow/er 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: (please circle)

_____

Any other secondary complaints:

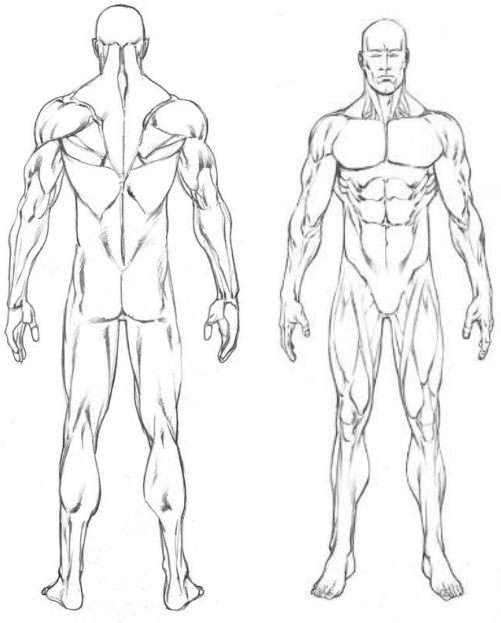
_____

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:_____