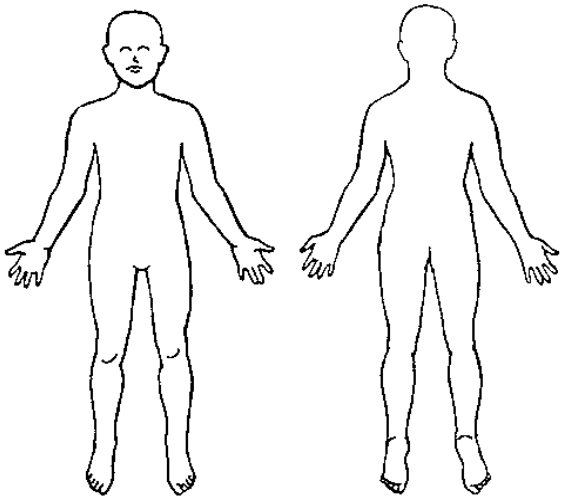
COUNTRY CHIROPRACTIC

PATIENT INTAKE INFORMATION **Date: ___/___/___**

NAME:	**SEX: M | F**	**DOB:**	**AGE:**
Address:			**Postcode:**
Phone (Home):	**Phone (Work):**	**Mobile:**	
Email:			
Marital Status:	**Spouses Name:**		
Children (List + Ages):			
Health Cover:	**Workers Compensation:**		
OCCUPATION:	**EMPLOYER:**		
How did you find our clinic? Person:	Website Signage Facebook Other:		

WHAT IS YOUR MAJOR HEALTH CONCERN?

Please indicate & circle where your present symptoms are on the diagram below using the symbols in the below



Aching Pain: A
Burning Pain: B
Stabbing Pain: S
Numbness/Pins/Needles: P
Other: (use your imagination)

Indicate the intensity of your pain below (circle):

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** WORST PAIN

Main Concern:

When did it start?

Have you had it before? **Y N**

Is it (circle): getting worse constant comes/goes getting better

What caused it / How did it happen?

Is the pain referring to other areas of your body?

What makes it better?

What makes it worse?

What treatment have you had? (circle) GP Chiro Physio Other:

How have these problems interfered with your activities?

Sporting ability / Fitness / Work ability?

Does this cause you to be:	**Does this affect your work/sport:**	**Does this affect your life:**
☐ Moody	☐ Poor attitude	☐ Lose patience with family/friends
☐ Irritable	☐ Decreased productivity	☐ Stop particular things you would like to do
☐ Interrupt Sleep	☐ Exhausted at end of day	
☐ Unable to cope	☐ Unable to work long hours	

Sleeping Posture: (circle) Side Back Stomach

Sports you play or used to play:

CHIROPRACTIC CARE:

Have you had Chiropractic Care before? **Y N**	Where you pleased with the services provided? **Y N**
Chiropractor/Clinic:	When was your last visit?
Have you had imaging in the past: (please list)	

OTHER PROBLEMS: (please tick and elaborate if necessary)

☐ Neck pain	☐ Stroke	☐ Dizziness or Vertigo
☐ Mid-back pain	☐ Asthma or Breathing Difficulty	☐ Epilepsy
☐ Low back pain	☐ Lung or Chest problems	☐ Sinusitis or Hay Fever
☐ Other joint pain:	☐ Abdominal pain	☐ Eyes, ears, nose, throat issues
☐ Numbness or Tingling	☐ Digestive issues	☐ Skin issues
☐ Scoliosis	☐ Kidney, bladder issues	☐ Allergies
☐ Spinal Surgery	☐ Reproductive issues	☐ Weight issues
☐ Osteoarthritis / Osteoporosis	☐ Heart or circulatory issues	☐ Anxiety/Depression
☐ Rheumatoid / Psoriasis	☐ Blood pressure issues	☐ Tired/Fatigued
☐ Cancer / Malignancy	☐ Headache or Migraine	☐ Difficulty sleeping

GENERAL HEALTH: (please answer to the best of your ability)

Current Health Care Practitioners: (who, and what for?)

List Vitamins/Supplements:

List Current Medications:

List all injuries:

Major Illnesses during lifetime:

Detail any motor vehicle accidents / other injuries:

List surgeries or hospital stays:

List previous x-rays, CT scans, MRI's:

Do you currently smoke? (circle) **Y** **N** How many? (per day) Did you Previously?

Do you drink alcohol? (circle) **Y** **N** Total per day? (Std Drinks)

Do you wear shoe inserts? (circle) **Y** **N** Details:

Do you wear a dental splint? (circle) **Y** **N** Details:

(Females) Are you currently pregnant? (circle) **Y** **N** Estimated Due date: Weeks:

(Females) Do you use a contraceptive pill? (circle) **Y** **N**

Anything else you would like us to know?

MISSED APPOINTMENT & PRIVACY POLICIES

I am aware of the Missed Appointment Policy and associated fees.
I consent to the collection of my personal information as outlined in the Privacy Policy.

Patient's Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

Please refer to our informed consent document and appropriate discussions with your practitioner.

I do **not** consent to the use of: Chiropractic Adjustments Dry Needling Cupping (circle if needed)

I have read the informed consent document and have discussed the information which is applicable to me with the practitioner and give my consent to treatment.

Patient / Parent / Guardian Name Signature Date

Chiropractors Signature: _____ Date: _____