Please Initial _____

ANDERSON FAMILY CHIROPRACTIC

Personal Information:

Date:_____

Full Legal Name:_____

D.O.B:_____ Preferred Name: _____

Postal Address:_____

_____ Suburb:_____ Post Code:_____

Home Phone #: _____ Mobile # :_____

Email address: _____

Marital Status: Single De facto Engaged Married Widow/er Partner's Name:_____

Children (Names & Ages):_____

Occupation: _____Date of last visit to a Chiropractor: _____

Name & City of previous Chiropractic Centre: _____

The biggest compliment to our clinic is the referral of your Family & Friends. **If you heard about us from a person**, please fill in their name so we can show them our appreciation:

_____

If it wasn't 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?_____

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

Parent/Guardian 1: _____

Parent/Guardian 2:_____

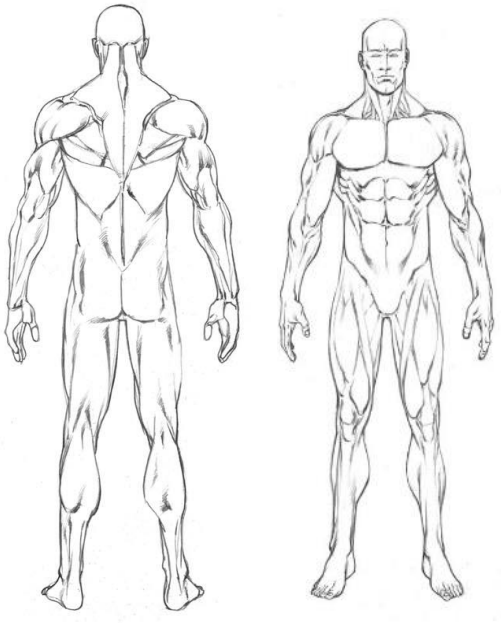
Who to Contact Regarding Appointments: Parent 1 / Parent 2 / Yourself

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:

_____

Do you know how your main problem started?_____

_____

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:

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 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?_____

Signature of Patient OR Legal Guardian:_____Date:_____

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? _____

PMS is a condition which can affect a person's emotions, physical health, and behaviour during certain days of the menstrual cycle, generally just before the menses.