



**CONFIDENTIAL
PATIENT
INFORMATION**

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CASE NO.

TODAY'S DATE

NAME	HOME (
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ADDRESS	WORK (
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	MOBILE (
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AGE	DATE OF BIRTH	MARITAL STATUS M S W D	eMAIL ADDRESS
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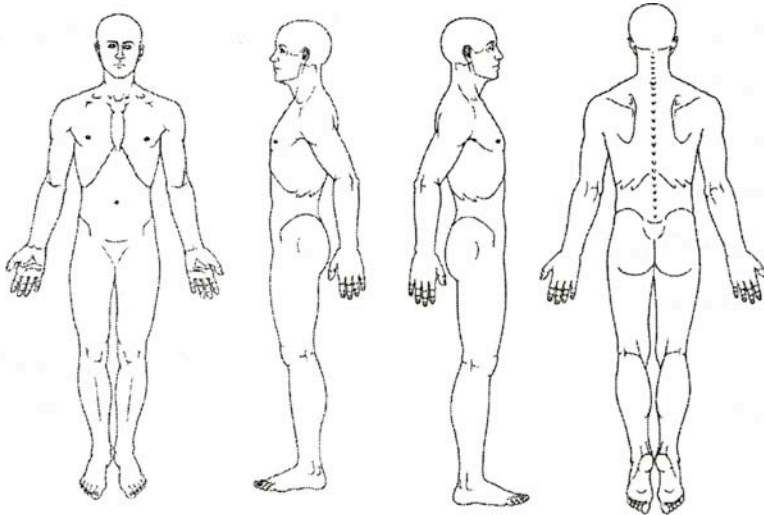
OCCUPATION	EMPLOYER
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WHO REFERRED YOU TO OUR CENTRE?

WHAT IS THE PURPOSE OF THIS APPOINTMENT (MAJOR COMPLAINT)?
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PLEASE USE THE DIAGRAMS TO INDICATE SITE/S OF PAIN: PAIN = XXXXX NUMBNESS/TINGLING = ///////////////



WHAT DO YOU BELIEVE IS WRONG WITH YOU?
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WHEN DID THIS PROBLEM BEGIN?

WHAT AGGRAVATES THE CONDITION?

WHAT RELIEVES THE CONDITION?

IS THIS CONDITION: <input type="checkbox"/> WORSENING <input type="checkbox"/> IMPROVING <input type="checkbox"/> CONSTANT <input type="checkbox"/> INTERMITTENT
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please turn over...

IS CONDITION DUE TO SICKNESS OR INJURY ARISING OUT OF EMPLOYMENT: q YES q NO	
HAVE YOU LOST ANY DAYS FROM WORK? q YES q NO	IF YES, HOW MANY?
HAVE YOU HAD THE SAME OR SIMILAR CONDITION PREVIOUSLY? q YES q NO	IF YES, WHEN?
OTHER DOCTORS/PRACTITIONERS SEEN ABOUT THIS CONDITION? q YES q NO	IF YES, WHOM?
HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? q YES q NO	IF YES, WHOM?

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITIONS IN THE PAST YEAR? q YES q NO		
IF YOU ARE FEMALE, IS THERE A POSSIBLTY YOU ARE PREGNANT? q YES q NO	IF YES, DUE DATE?	
WHAT OPERATIONS HAVE YOU HAD?		
HAVE YOU HAD, OR DO YOU HAVE, ANY SERIOUS ILLNESS?		
WHAT MEDICATIONS ARE YOU TAKING?		
HAVE YOU EVER BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT? q YES q NO	IF YES, WHEN?	
DESCRIBE		
HAVE YO EVER SUFFERED FROM?		
q HEADACHE	q LOW BACK PAIN	q NECK PAIN OR STIFFNESS
q SCIATICA	q ASTHMA	q EAR NOISES
q EYE PAIN	q FAILING VISION	q HAY FEVER
q SINUS INFECTION	q HIGH BLOOD PRESSURE	q LOW BLOOD PRESSURE
q PAIN OVER HEART	q STROKE	q CHEST PAIN
q DIFFICULTY BREATHING	q CONSTIPATION	q CANCER
q FREQUENT URINATION	q PROSTATE TROUBLE	q IRREGULAR MENSTRUAL CYCLE

SIGNATURE
SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR