

## Confidential Patient Case History

Please complete the following questionnaire. It will help determine if Chiropractic care can help you.  
(please print)

Name	Date	Case #
Address		Postcode
Telephone (h)	(w)	(m)
Email	Occupation	
Date of birth	Marital status	Children
How did you find out about us?		
Are you in a Health Fund? <input type="radio"/> Yes <input type="radio"/> No    If so, which one?		

**Have you suffered from any of the following?** Tick appropriate circle:  Present  Past

- |   |  |  |  |
|---|--|--|--|
| <input type="radio"/> Pins & needles of hands | <input type="radio"/> Knee trouble         | <input type="radio"/> Headaches          | <input type="radio"/> Allergies            |
| <input type="radio"/> Loss of grip            | <input type="radio"/> Foot/ankle trouble   | <input type="radio"/> Nervousness        | <input type="radio"/> Vomiting             |
| <input type="radio"/> Wrist or hand pain      | <input type="radio"/> Pins/needles of feet | <input type="radio"/> Insomnia           | <input type="radio"/> Constipation         |
| <input type="radio"/> Mid back pain           | <input type="radio"/> Scalp disorders      | <input type="radio"/> Dizziness          | <input type="radio"/> Diarrhoea            |
| <input type="radio"/> Mid back tension        | <input type="radio"/> Pain in head         | <input type="radio"/> Loss of smell      | <input type="radio"/> Abdominal pain       |
| <input type="radio"/> Pain in ribs            | <input type="radio"/> Soreness in neck     | <input type="radio"/> Sinus trouble      | <input type="radio"/> Piles                |
| <input type="radio"/> Low back pain           | <input type="radio"/> Shoulder pain        | <input type="radio"/> Ear disorders      | <input type="radio"/> Urinary disorders    |
| <input type="radio"/> Low back weakness       | <input type="radio"/> Shoulder stiffness   | <input type="radio"/> Hay fever          | <input type="radio"/> Bed wetting          |
| <input type="radio"/> Low back stiffness      | <input type="radio"/> Shoulder tension     | <input type="radio"/> Sore throat        | <input type="radio"/> Menstrual problems   |
| <input type="radio"/> Hip pain/stiffness      | <input type="radio"/> Arm pain             | <input type="radio"/> Asthma             | <input type="radio"/> Loss of potency      |
| <input type="radio"/> Buttock pain            | <input type="radio"/> Elbow pain           | <input type="radio"/> Chronic cough      | <input type="radio"/> Sexual disorder      |
| <input type="radio"/> Leg pain                | <input type="radio"/> Loss of arm power    | <input type="radio"/> Stomach tension    | <input type="radio"/> Tension chronic      |
| <input type="radio"/> Leg cramps              | <input type="radio"/> Eye disorders        | <input type="radio"/> Digestive problems | <input type="radio"/> Irritability chronic |
| <input type="radio"/> Pins/needles legs       | <input type="radio"/> Loss of taste        | <input type="radio"/> Nausea             | <input type="radio"/> Fatigue chronic      |
|   |  |  | <input type="radio"/> Sleeping problem     |

### Present symptoms

What are your present symptoms?

Onset date: Original	Recent	Caused by
Previous treatment by		Result
Any family history of this problem?		<input type="radio"/> Yes <input type="radio"/> No
Is your major symptom aggravated by or related to your work?		<input type="radio"/> Yes <input type="radio"/> No
What medications are you taking?		
What serious illnesses have you had?		
Do you sleep on <input type="radio"/> Side <input type="radio"/> Back <input type="radio"/> Stomach		
What type of mattress do you have?		How many pillows?

### Pregnancy

- Is there any possibility that you might be pregnant?     Yes     No
- Please enter date of the first day of the last menstrual period

