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? O Yes O No If so, which one? ______

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

- **O** O Pins & needles of hands
- **O** O Loss of grip
- **O** O Wrist or hand pain
- **O** O Mid back pain
- **O** O Mid back tension
- **O** O Pain in ribs
- **O** O Low back pain
- **O** O Low back weakness
- **O** O Low back stiffness
- **O** O Hip pain/stiffness
- **O** O Buttock pain
- **O** O Leg pain
- **O** O Leg cramps
- **O** O Pins/needles legs
- **O** O Knee trouble
- **O** O Foot/ankle trouble
- **O** O Pins/needles of feet
- **O** O Scalp disorders
- **O** O Pain in head
- **O** O Soreness in neck
- **O** O Shoulder pain
- **O** O Shoulder stiffness
- **O** O Shoulder tension
- **O** O Arm pain
- **O** O Elbow pain
- **O** O Loss of arm power
- **O** O Eye disorders
- **O** O Loss of taste
- **O** O Headaches
- **O** O Nervousness
- **O** O Insomnia
- **O** O Dizziness
- **O** O Loss of smell
- **O** O Sinus trouble
- **O** O Ear disorders
- **O** O Hay fever
- **O** O Sore throat
- **O** O Asthma
- **O** O Chronic cough
- **O** O Stomach tension
- **O** O Digestive problems
- **O** O Nausea
- **O** O Allergies
- **O** O Vomiting
- **O** O Constipation
- **O** O Diarrhoea
- **O** O Abdominal pain
- **O** O Piles
- **O** O Urinary disorders
- **O** O Bed wetting
- **O** O Menstrual problems
- **O** O Loss of potency
- **O** O Sexual disorder
- **O** O Tension chronic
- **O** O Irritability chronic
- **O** O Fatigue chronic
- **O** O 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? O Yes O No

Is your major symptom aggravated by or related to your work? O Yes O No

What medications are you taking? ______

What serious illnesses have you had? ______

Do you sleep on O Side O Back O Stomach

What type of mattress do you have? ______ How many pillows? ______

Pregnancy

1. Is there any possibility that you might be pregnant? O Yes O No
2. Please enter date of the first day of the last menstrual period ______