Confidential Case History - Adult

CHOICE CHIROPRACTIC
changing spines, changing lives...
www.choicechiropractic.com.au

Welcome

The purpose of this practice is to restore and improve health and quality of life in every adult and child that is cared for in this practice. Chiropractors specialise in locating and correcting vertebral subluxations. Vertebral subluxations are spinal bones that have lost their normal alignment and function through trauma, injury or stress. These Vertebral subluxations put pressure on your nervous system and cause abnormal function within your body, this dysfunction results in pain and ill health.

For us to understand your health problem we need a complete history of your present and previous symptoms and treatment.

Name: _____ ❒ Male ❒ Female

Address: _____

Suburb: _____ Postcode: _____

Telephone (Home): _____ (Work): _____ (Mobile): _____

Email Address : _____ Date of Birth: ___/___/___ Age : _____

Occupation: _____

Employer: _____

Marital Status: _____ Spouses / Guardians Name: _____

No. of Children and ages: _____

How did you find out about this practice ? Friend ❒ Family Member ❒ Yellow pages ❒ Other ❒

Referred by : _____

Are you a member of a fund that covers Chiropractic Care? ❒ Yes ❒ No ❒ Not Sure

If Yes, what is the name of your fund ? _____

Is this a Work Cover case? ❒ Yes ❒ No ❒ Not Sure

Is this a Transport Accident case? ❒ Yes ❒ No ❒ Not Sure

Have you had previous Chiropractic Care? ❒ Yes ❒ No

If yes, name of previous Chiropractor? _____

Where were they located? _____

Were X-rays taken? ❒ Yes ❒ No If yes, when? _____

When was your last treatment? _____

What were the results of your treatment?

❒ Excellent ❒ Satisfactory ❒ Fair ❒ Did not help ❒ Got worse

SYMPTOMS AND ILL HEALTH

What is your major complaint?_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

What activities aggravate your condition?_____

What activities improve your condition?_____

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Constant ❒ Comes & Goes

Is this condition interfering with your: ❒ Work ❒ Sleep ❒ Daily Routine

List previous care you have received for present condition?_____

_____

Do you have any other complaints?_____

List any surgical operations and year they were performed:_____

_____

List any medication or supplement you take:_____

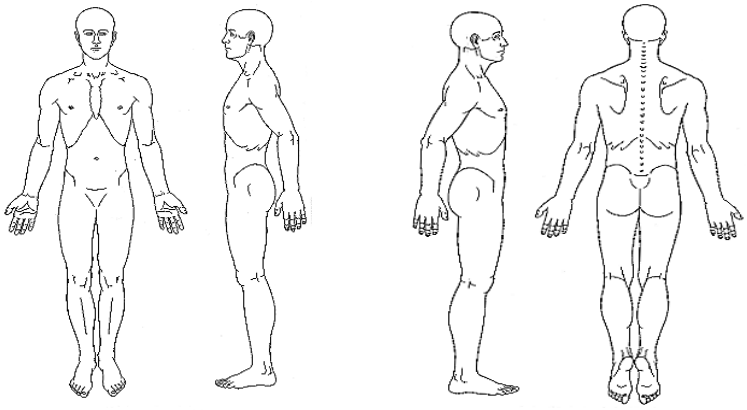
Have you been involved in a motor vehicle accident? When?_____

List the major traumas/accidents/falls you have sustained:

1._____ 2._____

3._____ 4._____

Please indicate the location of your chief complaint on these diagrams:



How would you rate your pain ?
(place a mark on this line)

0 _____ ***10***

(no pain) ***(severe pain)***

HEALTH QUESTIONNAIRE: Tick which of the following you have experienced:

Heart Condition	❒	Tuberculosis	❒	Sleeplessness	❒
Blood Pressure	❒	Cancer	❒	Sinus Condition	❒
Breathing Difficulties	❒	Fatigue	❒	Ulcer	❒
Asthma	❒	Headaches	❒	Diabetes	❒
Rheumatic Fever	❒	Constipation	❒	Nervousness	❒
Hay fever	❒	Diarrhoea	❒	Anaemia	❒
Indigestion or Stomach Pain	❒	Skin Condition	❒	Arthritis	❒
Kidney or Urinary Trouble	❒	Menstrual Problems	❒	Other?_____	

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, including where covered by Transport Accident Commission (TAC) or WorkCover.

SIGNATURE OF PATIENT OR GUARDIAN _____