Personal Details CONFIDENTIAL info@farrellychiropractic.com.au 9704-6567

Please use a **BLACK PEN ONLY** as our scanner will only pick up black pen

NAME:Mr/Mrs/Ms/Dr_____**DATE**:_____

ADDRESS:_____**POSTCODE**:_____

MOBILE:_____ **HOME**: _____ **WORK**: _____

EMAIL:_____**DATE OF BIRTH**:_____**OCCUPATION**: _____

EMERGENCY CONTACT PERSON:_____**PHONE**:_____

HEALTH INSURANCE? _____Are you covered for chiropractic care? Yes / No

Is this condition related to **WorkCover** [ ] or **TAC** [ ] ? [ ] No

Who is your regular doctor (**General Practitioner**)? _____

Our practice grows by referral. Who may we thank for referring you?_____

Have you seen a chiropractor before? Yes [ ] Who?_____ No [ ]

We will explain everything as we go and only proceed once you are completely comfortable.

Major Complaint **What are your main problem/s?**

_____

_____

When and how did it start_____

Was there any of the following prior to or during the onset? (Please tick if yes)

Illness **Infection** **Trauma** **Other significant event**

Is it getting **worse**? What **relieves** it? _____What **aggravates** it?_____

Are your symptoms worse at night or any specific time of the day? _____

Do you have any **pain traveling down your arms or legs**? Yes /No_____

Does your **current problem** involve any of the following?

Tingling in either arm or leg? **Numbness** in either arm or leg?

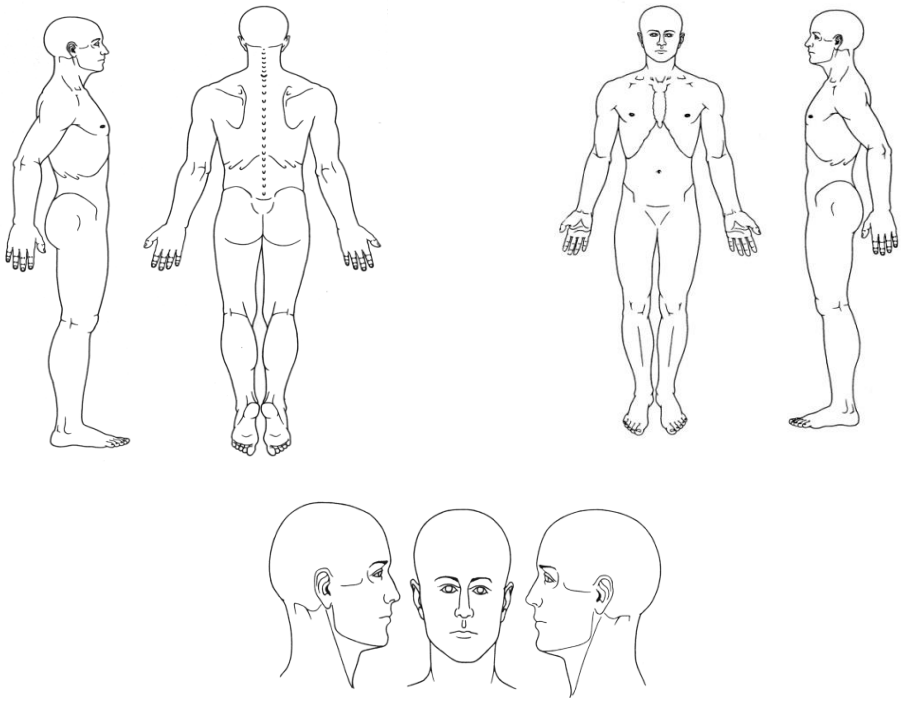
Weakness in either arm or leg? **'Weird' sensations** in either arm or leg?

Have you had any **other treatment** for your current problem? Please list below

_____

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern



Medical History & General Health

Please tick ✓ where applicable:
Do you smoke? Do you drink alcohol? Do you exercise regularly?

Do you take vitamin supplements? List _____

Have you had any surgery? Please list below and the date of operation.

1_____ 2_____ 3_____ 4_____

Are you currently taking any form of medication? If yes, list all of them please.

1_____2_____3_____4_____

Have you ever had a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Please list below.

_____

Have you had any broken bones/fractures? If yes, which ones and how?

_____

Have you had any falls or sports injuries? If yes, when and describe

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Please list below.

_____

Do You Suffer from Any of the Following? Please tick ✓ if yes

Allergies List_____

Asthma
Hayfever
Sinusitis
Frequent coughs/colds

Thyroid Problems

Fertility Problems
Period Pains

Fatigue
Poor sleep
Occupational stress

Painful joints If yes, is it worse in the night?

Joint swelling?

Wake up with stiffness or aching in your joints or muscles?

Waking in the early hours and being unable to sleep again?

Headaches or Migraines
If yes: Are they throbbing and accompanied by nausea or vomiting?

Shoulder pain
Pain in between the shoulder blades

Carpal Tunnel
Elbow Pain
Rheumatoid Arthritis
Psoriasis

Pain in the buttock area
Sciatica
Knee Pain

Pain or aching in your stomach.
If yes: Is it relieved by eating or by drinking milk?

Persistent change in your appetite during the last three months

Has your weight changed more than 4 Kg in the last year?

Irritable Bowel
Loose bowel movements
Constipation
Blood or mucus in your bowel movements
Haemorrhoids

Shortness of breath on exertion

Pain or tightness in your chest on exertion. If Yes. Is it relieved by resting?

Cramp-like pain in either leg when walking? If Yes. Do you have to stop or slow down to relieve it?

Cold hands / feet

Varicose veins

Heart seems to miss a beat
Frequent or persistent cough

Difficulty passing water
Passing water more frequently lately

Lumps, cysts, or unusual swellings anywhere on your body

Easily depressed
Difficulty concentrating

Does stress seem to make your main problem worse?

Are you subject to blackouts, dizzy spells, or fainting?

Car/motion sickness

Poor balance

Our practice focuses on treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their **medical practitioner**. As such, it is standard practice to correspond with your medical practitioner where appropriate.

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my GP where appropriate.

(Signature)_____**(Print Name)**_____**(Date)**_____

Please give 24 hours' notice if you wish to change any future appointments, otherwise a **$25 booking fee may be charged. We appreciate your co-operation by notifying us of any changes to your schedule.**