farrelly chiropractic

Personal Details CONFIDENTIAL

TODAYS DATE: ___________________

NAME: ____ **DATE OF BIRTH**: ___________________

ADDRESS: ____ **SUBURB**: _________________ **POSTCODE**: ______

MOBILE: ____ **HOME**: _____________________________________

EMAIL: ____ **OCCUPATION**: ______________________________

EMERGENCY CONTACT: _________________________________ **PHONE**: ___________________________________

HEALTH INSURANCE? __________________________________ Are you covered for **chiropractic care**? Yes / No

Is this condition related to **Workcover** Yes / No? or **TAC** Yes / 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 /No If yes who? ________________________________

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

Major Complaint What are you seeking help for today? ____________________________________

____

When did it start? ______________ How did it start? ____

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

Infection **Trauma/Injury** **Illness** **Other significant event**

Is it getting **worse**? Yes / No 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?

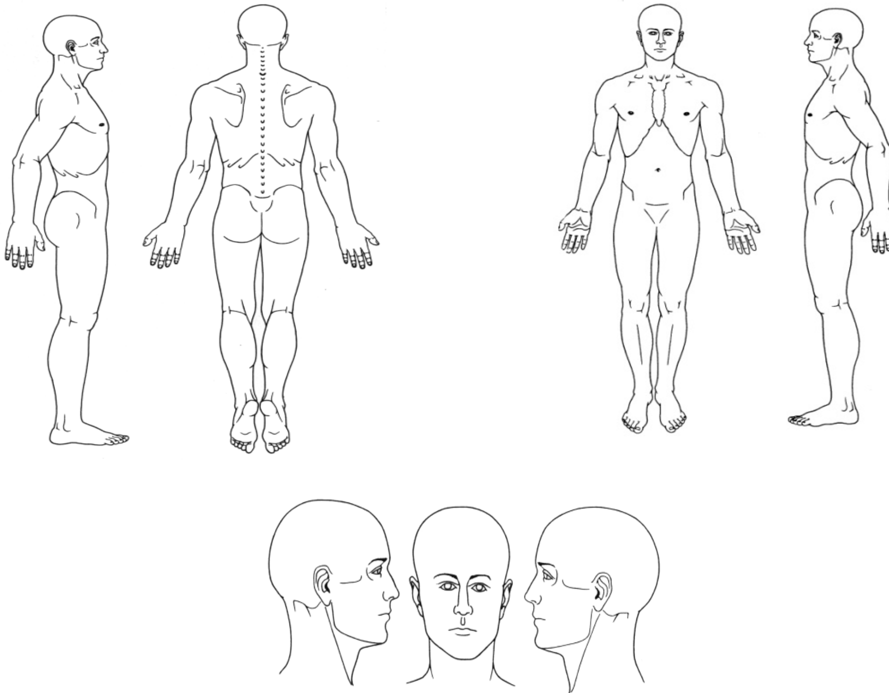
Weakness in either arm or leg? **'Weird' sensations** in either arm or leg?

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

Do you smoke? Yes / No Do you drink alcohol? Yes / No Do you exercise regularly? Yes / No

Do you take **vitamin supplements?** Yes / No List ____

Have you had any **surgery?** Yes / No Please list below and the year of surgery.

1______________________2______________________3_______________________ 4______________________

Are you currently taking any form of **medication?** Yes / No If yes, list **all** of them please.

1______________________2______________________3_______________________4______________________

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

____

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? Please list.
(e.g. cancer, diabetes, heart disease or any other major health problem)

____

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

Allergies List____

Asthma
Hay fever
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.

Print Name__________________________ Signature_____________________________ Date____________

Please give 24 hours' notice if you wish to change any future appointments, otherwise, a $30 booking fee may be charged. We appreciate your cooperation in notifying us of any changes to your schedule.