Blackwood Chiropractic Centre

Name: _____ D.O.B: _____ Gender: M / F

Address: _____ Post Code: _____

Phone: _____Mobile: _____ Occupation: _____

Email: _____

How did you hear about the clinic? (family / friend, drive by, google) _____

Referred by: _____ (Name/s of friend/family/GP etc who recommended clinic)

Health Cover (Extras): Y / N Fund Name: _____ Number Next to Name: _____

Next of Kin (In case of Emergency): _____ Phone: _____

Have you received previous Chiropractic care?: Y / N By whom/Clinic: _____

Name of GP: _____ Last visit: _____

CASE HISTORY

Please describe your current complaint:

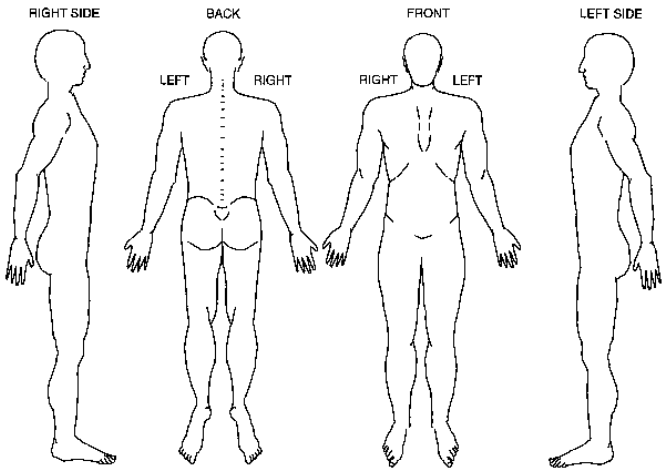
_____

When and how did this occur?:

_____

Is this a new condition?: Y / N

Please mark on the diagrams where you experience pain/discomfort:



How would you describe your condition?: *tick appropriate*

( ) Sharp ( ) Dull ( ) Ache ( )Stiff ( ) Constant

( ) On & Off ( ) Pins & Needles ( ) Numbness

Rate your current level of discomfort:

0 1 2 3 4 5 6 7 8 9 10

No pain/discomfort ⇨ **maximal pain/discomfort**

Does anything aggravate your condition?

_____

Does anything relieve your condition?

_____

Do you have any other conditions you would like addressed?

_____

MEDICAL AND LIFESTYLE HISTORY

Please provide details for the relevant following sections:

Fractures / Dislocations: _____
Operations: _____
Hospitalisation: _____
Serious Illness: (past or present): _____
Medications: _____
_____

Do you or your immediate family have a history of the following conditions?:

( ) Stroke - Self / Parent / Sibling / Grandparent
( ) Cancer - Self / Parent / Sibling / Grandparent
( ) Diabetes - Self / Parent / Sibling / Grandparent
( ) Heart Condition - Self / Parent / Sibling / Grandparent
( ) Osteoporosis - Self / Parent / Sibling / Grandparent

MEDICAL SYSTEMS REVIEW

The following information helps us understand you and your condition better, please mark the boxes that apply to you:

GENERAL
( ) weight loss/gain
( ) fatigue
( ) loss of appetite
( ) cancer
( ) anaemia

EYES, EARS, NOSE, THROAT
( ) glasses
( ) visual disturbances
( ) hearing disturbances
( ) sore throat
( ) nose bleeds

SKIN
( ) skin problems
( ) easy bruising
( ) slow healing
( ) rashes
( ) mole changes

CARDIOVASCULAR
( ) chest pain or pressure
( ) high/low blood pressure
( ) high cholesterol
( ) heart problems

RESPIRATORY
( ) cough
( ) difficulty breathing
( ) asthma
( ) lung problems

NEUOROLOGICAL
( ) dizziness/light headed
( ) memory problems
( ) headaches/migraine
( ) weakness

GASTROINTESTINAL
( ) pain over stomach
( ) changes in bowel habits
( ) constipation/diarrhea
( )blood in stool
( ) reflux

GENITOURINARY
( ) painful urination
( ) frequent urination
( ) incontinence
( ) blood in urine
( ) kidney/urinary infection

IMMUNOLOLGIC
( ) sinus troubles
( ) allergies/hayfever
( ) current fever
( ) frequent colds/flu
( ) HIV

MUSCULOSKELETAL
( ) arthritis
( ) osteoporosis
( ) spinal trauma
( ) birth trauma
( ) joint / muscle pain

WOMENS HEALTH
( ) irregular periods
( ) painful periods
( ) vaginal discharge
( ) breast lumps
( ) menstrual cramps

MENS HEALTH
( ) difficulty urinating
( ) prostate problems
( ) testicular lumps
( ) prostate/testicular cancer

Any other information/conditions you wish to share?

_____
_____
_____