adelaide family chiropractic

Confidential Patient Information

Name:
Address:
Date of Birth: / /
Gender: ❑ M ❑ F
Home Phone:
Mobile Phone:
Email:

Emergency Contact:

Name: Phone: Relationship:

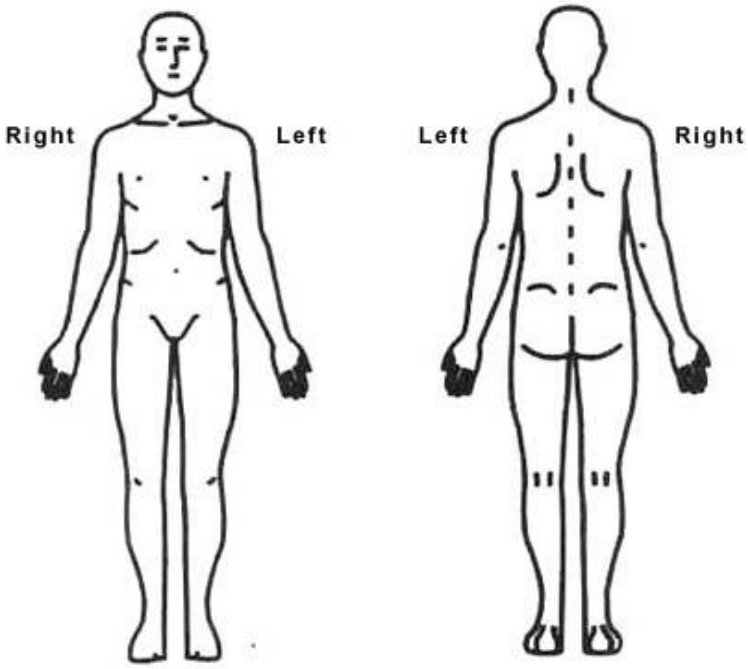
How did you hear about our office?

❑Friend / Family
❑Google
❑Facebook
❑Yellow Pages Online
❑Health Fund
❑Drive by / Local Resident / Signage
❑GP
❑Dentist
❑Midwife
❑Lactation Consultant
❑CrossFit / Local Gym
❑Other:

Please tick the reason(s) for pursuing chiropractic care for yourself or your child:

❑ I have a specific condition(s) that concerns me
❑ I am interested in a Spinal Health Assessment / Check
❑ I am interested to learn ways to improve Health, Posture or Function
❑ I am interested in performing better at work, at home or at sport / recreation
❑ I want the best health and function during/for pregnancy

Draw on diagram area of Complaint:
(If filling this form digitally, you can fill this diagram at the Chiropractic office)



Patient Signature:
Date:

*If **you** or **your child** has a specific concern, please describe below:*
Otherwise, leave blank and continue over page

Describe the condition that concerns ***you*** or ***your child***:	CC
When did this condition begin?	O
How did this condition happen?	M
What relieves this condition? What aggravates this condition?	Pall Prov
Has this condition: ❑ gotten worse ❑ stayed constant ❑ come and gone	Prog
Describe how the complaint feels: Is there numbness / tingling anywhere in the body? ❑ yes ❑ no If yes, where? Is there pain radiating / shooting anywhere in the body? ❑ yes ❑ no If yes, where?	Q R
Is the complaint worse: ❑ upon waking ❑ day ❑ afternoon ❑ at night ❑constant	T
Grade intensity/severity (none) 0 1 2 3 4 5 6 7 8 9 10 (worst) ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	I
Has this condition occurred before? ❑ yes ❑ no If yes, explain:	Hx
Is there any other areas of concern? ❑ yes ❑ no If yes, explain:	

Notes:
(Chiropractor to fill out)
@work:

@home:

@sport/recreation:

Patient Signature:
Date:

DC Initial _____
RKK Att: ❑

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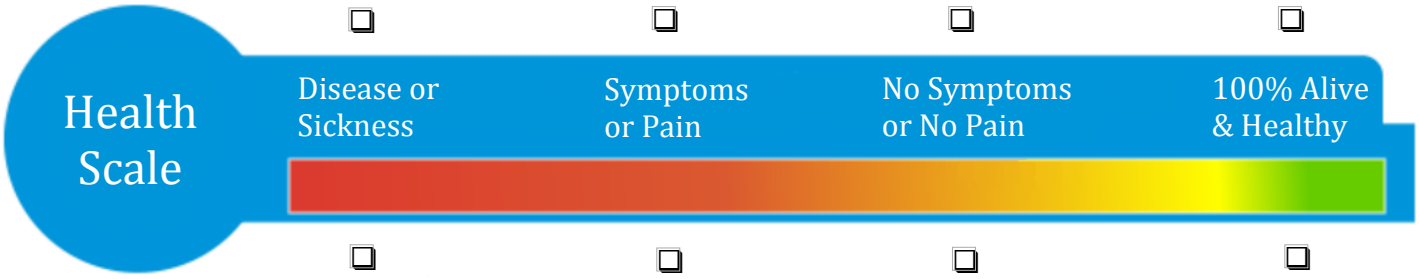
CHECK any condition you / your child have PRESENTLY or in the PAST:

GENERAL ❑Dizziness ❑Trouble swallowing ❑Fainting / Unexpected Fall ❑Slurred or Slow Speech ❑Visual Disturbance ❑Nausea ❑Numbness / Tingling ❑Poor Co-ordination	CARDIOVASCULAR ❑Blood Clot / Disorder ❑Heart Disease ❑Heart Attack ❑Stroke ❑Chest pain ❑Slow / Rapid beating heart ❑Low / High blood pressure	GENITOURINARY ❑Painful urination ❑Blood in urine ❑Kidney infection / stones ❑Prostate trouble ❑Difficulty / uncontrollable urination
NEUROLOGICAL ❑Epilepsy ❑Ringing in ears ❑Weakness	GASTROINTESTINAL ❑Heartburn / Ulcers ❑Ulcers ❑Vomiting ❑Blood in stool	RESPIRATORY ❑Chronic cough ❑Wheezing ❑Asthma
❑Arthritis ❑Cancer ❑Diabetes ❑Genetic Disorders ❑Osteoporosis ❑Fever / Sweats ❑Rapid weight loss / gain ❑Pain with cough/sneeze/ straining on toilet	WOMEN Are you pregnant? ❑yes ❑no	Is there anything else we should know about your health? ❑yes ❑no

List any surgery, significant illnesses and trauma:

1. _____Date:
2. _____Date:
3. _____ Date:
4. _____Date:
5. _____Date:
6. _____Date:

CHECK above the *Health Scale* where you believe your or your child's health is NOW:



CHECK below the *Health Scale* where you want your or your child's health to be:

Thank-you for completing these forms

Patient Signature:
Date: