

LAKESIDE CHIROPRACTIC CLINIC

Confidential Health History

This information is confidential. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond, we will not accept your case. Please answer all questions **truthfully** even if you think they are irrelevant as only your chiropractor is qualified to determine whether there is a connection to your complaint.

Full name _____ Title _____ Date of birth _____

Address _____ Suburb _____ Postcode _____

Tel _____ Occupation _____

How did you hear about us? _____

Main area of complaint _____

List any treatment you have received for this complaint _____

List any medications you are taking _____

E-mail Add: _____ Have you had Chiropractic care before? Y/N

Do you have any private health care? **Yes / No**

Do you have any children? **Yes / No** If yes, number & age of children: _____

Are you comfortable with the use of acupuncture needles? **Yes / No**

Please tick any that have applied within the last 3 months:

- | | | |
|---|---|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> upper or mid back pain | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> chest pain | <input type="checkbox"/> depression |
| <input type="checkbox"/> numbness in arms | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> persistent coughing |
| <input type="checkbox"/> double vision | <input type="checkbox"/> lower back pain | <input type="checkbox"/> bowel problems |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> leg pain | <input type="checkbox"/> bladder problems |
| <input type="checkbox"/> shoulder/arm pain | <input type="checkbox"/> numbness in legs or feet | <input type="checkbox"/> sinus trouble |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> blood pressure problems | <input type="checkbox"/> change in weight |
| <input type="checkbox"/> difficulty in rising to walk after sitting | <input type="checkbox"/> pain while walking | |
| <input type="checkbox"/> difficulty in standing | <input type="checkbox"/> pain while standing | |
| <input type="checkbox"/> difficulty in walking | <input type="checkbox"/> pain while sitting | |
| <input type="checkbox"/> difficulty in bending | <input type="checkbox"/> pain while coughing | |

Please tick the following conditions you have or have had:

- | | | | | | |
|-------------------------------------|-----------------------------------|--|---|---------------------------------------|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Any others... |

HAVE YOU EVER:

YES NO

- | | | |
|---------------------------------|--------------------------|--------------------------|
| Been knocked unconscious | <input type="checkbox"/> | <input type="checkbox"/> |
| Had a fractured bone | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Any personal injury or accident | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever been in an auto accident? YES/NO

If yes, state when

CONSENT TO EXAMINATION

I consent to an appropriate physical examination. Consent required by Parent/Guardian if patient is under 16 years of age. I understand that to the best of my knowledge the above to be an accurate health record

Signed _____ Date _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE.