# Chiropractic Care

EQUILIBRIUM FAMILY WELLNESS

Client No:

The human body is designed to be healthy. Throughout life, events occur which may damage your health expression. On a daily basis we experience physical, chemical and emotional stresses which may accumulate and result in a loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses that you have faced and the possible layers of damage to your nervous system.

**My purpose for seeking care in this clinic is:**
☐ Comprehensive health care for myself and my family
☐ Comprehensive health care for myself only
☐ Relief of my immediate symptoms only

## Personal Details

Mr. ☐ Miss. ☐ Ms. ☐ Mrs. ☐ Mst. ☐ Dr. ☐

Name: ........................................................................................................
First Middle Surname

Address: .................................................................................. Suburb: ..................................................

Postcode:.................. Phone: (H) ........................................ (Mob)............................................ (W) ...............................................

Date of Birth:.............................. Age:..................... Married ☐ Single ☐ Divorced ☐ Widowed ☐ Defacto ☐ Separated ☐

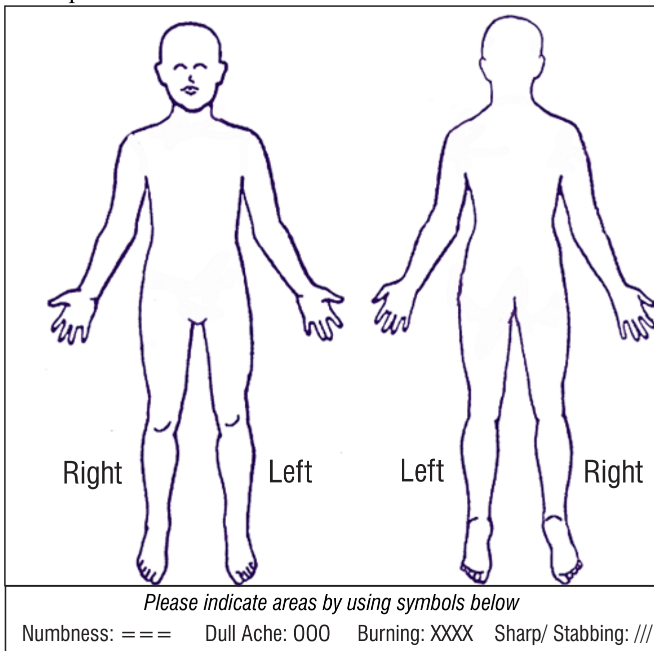
Next of Kin: .....................................................Children:...................... Your Occupation: ...................................................................

Employer & Address: ...................................................................

Who recommended you to the practice?...................................................

Email:.......................................................................................................

Would you like to receive our free email newsletter? Yes ☐ No ☐



*Please indicate areas by using symbols below*
Numbness: === Dull Ache: 000 Burning: XXXX Sharp/ Stabbing: ///

## Previous Chiropractic Care

Name of Chiropractor:.......................................................................................

What were you being seen for?.............................................................................

How many adjustments did you have?..............Last Adjustment date..........

Was your care: Excellent ☐ Satisfactory ☐ Unsatisfactory ☐

Where X-Rays Taken? Yes ☐ No ☐

## Other Previous Care

Please List any other forms of Treatment you have been under:

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## Previous & Current Health

What is your main complaint.........................................................................................................................................

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What caused this? ............................................................................................ How long have you had this for?..........................

What makes this complaint worse?.......................................................... What makes it better:..............................................................

Is the Pain: ☐ Sharp ☐ Burning ☐ Throbbing ☐ Dull ache ☐ Deep ☐ Numbness ☐ Tingling Other:.......................................

Is this complaint getting worse? Yes ☐ No ☐ Frequency of pain: ☐ Constant ☐ Comes & Goes Other:.......................................

Does this wake you at night? Yes ☐ No ☐

Is this complaint interfering with your: Work ☐ Sleep ☐ Daily Routine ☐ Other ☐

Have you had this or simular in the Past? YES NO

**Please rate your: CURRENT Pain by circling 'O' and Pain when at its WORSE by Crossing 'X'**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pain Rating** | No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Imaginable |
| **Disability Rating** | Can do any thing you want to | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Can't get out of bed |

List any previous diagnosis and care that you have had for this complaint:.....................................................................................

.....................................................................................................................................................................................

Please list other Health Complaints

| Complaint | Onset | Type of pain | What Caused your complaint |
|---|---|---|---|
| | | Sharp/Dull/Burning/Tingling/Numb | |
| | | Sharp/Dull/Burning/Tingling/Numb | |

List any surgical operations or hospital stays: (Year and Reason)......................................................................................................

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**Do you Have** ☐ Pacemaker ☐ Breast Implants Other Implantable Medical devices:.....................................................................

List all medications, health supplements or recreational drugs that you have used recently:.......................................................

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**Exercise** ☐ Sedentary ☐ Mid Exercise (walking 30 -45min, Golf) ☐ Regular Vigorous Exercise

**Alcohol** ☐ Yes ☐ No Number of drinks per week:............ **Smoking** ☐ Yes ☐ No Number of pack per week:...........

**Family History** Are there any health disorders in your family: (i.e. diabetes, heart / lung disease, cancer, stroke, thyroid disease.)

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Do you have good bladder & bowel control? ☐ Yes ☐ No Do you have good balance? ☐ Yes ☐ No

Medical Doctors: Name & Address: ......................................................................................................................................

**Trauma**: (Motor Vehicle Accidents, Falls, Sporting Injury, Bone Fractures, Dislocation, Concussion)

| Injury Type | Date of Injury | Description |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**symptoms / illness** Please tick (✓) any of the conditions you have now. Please cross (✗) any of the conditions you have had in the past.

☐ Headaches
☐ Neck pain
☐ Back pain
☐ Stiff neck
☐ Dizziness
☐ Vertigo
☐ Loss of balance
☐ Blind spot in vision
☐ Light bothers eyes
☐ Ears ring
☐ Loss of smell
☐ Loss of taste

☐ Difficulty swallowing
☐ Bad breath
☐ Cold sweats
☐ Face flushed
☐ Regular colds & flu
☐ Tension
☐ Irritability
☐ Fatigue
☐ Depression
☐ Nervousness
☐ Pins & needles in arms
☐ Pins & needles in legs

☐ High blood pressure
☐ Low blood pressure
☐ Numbness in fingers
☐ Numbness in toes
☐ Feet cold
☐ Hands cold
☐ Eczema
☐ Loss of memory
☐ Allergies
☐ Diabetes
☐ Fever
☐ Nausea

☐ Asthma
☐ Chest pain
☐ Shortness of breath
☐ Fainting
☐ Epilepsy
☐ Muscle cramps
☐ Diarrhoea
☐ Stomach upset
☐ Constipation
☐ Painful / clicking jaw
☐ Weight Loss
☐ Stroke

☐ Diabetes
☐ Heart Attack
☐ Heart Disease
☐ Lung Disease
☐ Cancer
☐ Incontinence
☐ Thyroid Disease
☐ Osteoporosis
☐ ____________
☐ ____________
☐ ____________
☐ ____________

**Female** Are you pregnant? Yes ☐ No ☐

☐ Menopausal symptoms
☐ Excessive menstrual flow
☐ Painful menstruation

☐ Cramps or backache
☐ Lumps in breasts
☐ Vaginal discharge

☐ Hot flushes
☐ Irregular cycles
☐ Painful intercourse

☐ Congested breasts
☐ Altered sex drive
☐ Urinary track infection

☐ ____________
☐ ____________
☐ ____________

**Male**

☐ Prostate problems
☐ Pain in testicles

☐ Impotence
☐ Premature ejaculation

☐ Altered sex drive
☐ Undescended testicles

☐ Groin pain
☐ ____________________

**Please tick (✓) if you have or had any of the following.**

☐ Silver Amalgam (Mercury) Fillings ☐ Root Canals ☐ Exposure to Toxins ____________________________

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To the best of my knowledge, the above is a true and accurate history. I understand that results from care cannot be guaranteed. I understand my financial obligations regarding this examination and any future care. I understand that payment is expected at the time of consultation.

Signature:__________________________________________ Date:____________________

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