Welcome…

CHIROPRACTOR
CARINE GLADES

Personal Information:

Full Name: _____ Preferred Name: _____

Address: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

Email_____ DOB: ____/____/_____

Occupation_____ Marital Status: ☐S ☐M ☐D ☐W ☐Def

Whom may we thank for referring you to us? _____

Is your visit related to either a motor vehicle or work related accident? ☐Yes ☐No

Information regarding your visit today:

Reason for today's visit: _____

When did symptoms begin? (Date) __/__/__ Have you had similar conditions in the past? _____

What aggravates the condition? _____

What improves the condition? _____

What previous medical treatment have you received? _____

Have you had chiropractic care previously? ☐ Yes ☐ No If yes, date of last treatment: __/__/__

List any medications you are taking: _____

Previous traumas (falls, MVA, concussions, fractures): _____

List previous surgical intervention: _____

Please indicate if you are currently, or have previously suffered any of the following:

	Past	Present		Past	Present
Neck Pain			Lower back pain		
Neck Stiffness			Mid back pain		
Headaches			Chest pains		
Migraines			Hip pain		
Shoulder Pain			Numbness in legs/feet		
Numbness arms/hands			Knee pain		
Dizziness/fainting			Jaw pain		
Seizures/epilepsy			Arthritis		
Nausea/vomiting			High blood pressure		
Chills/fevers/sweats			Low blood pressure		
Elbow/wrist/hand pain			Menstrual disorder		
Asthma			Kidney/bladder problems		
Hay fever/allergies/sinusitis			Liver/gallbladder problems		
Indigestion			Stomach ulcers		
Difficulty breathing			Constipation/diarrhoea		
Ear infections			Gout		
Nose bleeds			Cancer		
Ringing in ears			Diabetes		
Depression			Any other – please specify overleaf		

Please turn overleaf

If you are suffering from any other health issues, please specify:_____

Activities and movements which are difficult/painful to perform:

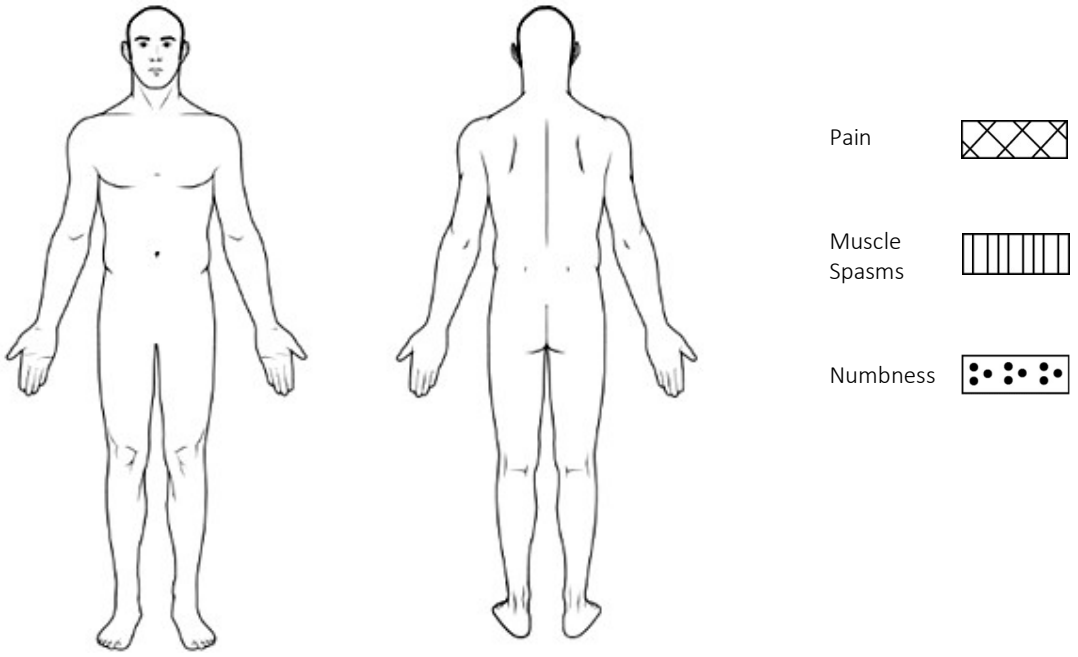
☐ Sitting ☐ Walking ☐ Bending over
☐ Lying down ☐ Lifting ☐ Coughing/sneezing

Type of pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning
☐ Tingling ☐ Numbness ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other

Is your pain interfering with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Leisure

Show areas of pain or unusual feeling. Mark the areas on the diagram using the appropriate shading.



On a scale of 0-10 (0 being no pain, 10 excruciating), please rate your pain:

0	1	2	3	4	5	6	7	8	9	10

Authorisation

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorise the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges. *(Payment is due in full at time of treatment).*

Signature_____Date_____