



CONFIDENTIAL PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Title: _____ First Name: _____ Surname: _____

Address: _____

Suburb: _____ Postcode: _____

Telephone: Home: _____ Mobile: _____ Work: _____

Email Address: _____

DOB: _____ Age: _____ Occupation: _____

Marital Status: _____ Partner's name: _____ No. of Children _____

Emergency contact name: _____ Relationship to you: _____

Emergency Contact Phone: _____

General Medical Practitioner: _____ Phone: _____

Is this a Workcover/TAC/DVA claim? Yes/No Claim number: _____

Do you have private health insurance? Yes/No Name of fund: _____

Is this your first visit to a chiropractor? Yes/No

If you have had previous chiropractic care, please complete the following

Name of chiropractor: _____ Location: _____

When was your last treatment? _____ How many treatments were given? _____

Were the results of the treatment Excellent/Satisfactory/Unsatisfactory?

Did the chiropractor use x-rays? Yes/No

How did you hear about Northern Beaches Chiropractic?

- Yellow Pages Google Signs
- Local Directories Facebook Flyers
- GP/other practitioner referral: _____
- Friend/Family: _____
- Other: _____

PATIENT HISTORY QUESTIONNAIRE

The following questions are to help your chiropractor diagnose your condition and develop the best treatment plan for you.

GENERAL HEALTH STATUS

Do you suffer, or have you suffered any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headache | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart issues | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Blood Pressure High/Low | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Menopause | <input type="checkbox"/> Swelling of joints/limbs |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain/numbness/tingling | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Dizziness | o Arm/Hand | <input type="checkbox"/> Visual disturbance |
| <input type="checkbox"/> Epilepsy | o Leg/Foot | <input type="checkbox"/> Smoke _____ day |
| <input type="checkbox"/> Fatigue | o Neck | <input type="checkbox"/> Alcohol _____ day |
| <input type="checkbox"/> Gastrointestinal complaints | o Mid Back | <input type="checkbox"/> Other _____ |
| | o Low Back | _____ |
| | <input type="checkbox"/> Polio | |
| | <input type="checkbox"/> Recent weight gain/loss | |

Please list:

- any hospitalizations you have had in the past _____
- _____
- drugs, medications or vitamins/minerals that you take _____
- _____
- any exercise/sports/activities _____
- _____

Females only: are you pregnant? Yes/No

Are you taking the contraceptive pill? Yes/No

PATIENT HISTORY QUESTIONNAIRE

Please mark the area/s of complaint on the diagram below

What is your main complaint?

.....

How did it start?

.....

How long have you had it?

Have you had it in the past? Yes/No
 How often are you experiencing it?

.....

What activities aggravate the complaint?

.....

What activities relieve the complaint?

Have you had any other treatment for this complaint?:

Is it: Getting better Getting worse Staying the same

Is it: Constant On & Off

Would you describe the pain as: Dull Achey Sharp Stabbing
 Shooting Burning Tingling Numb

Is it interfering with your: Work Sleep Sport Daily activities

Do you have any other complaints?

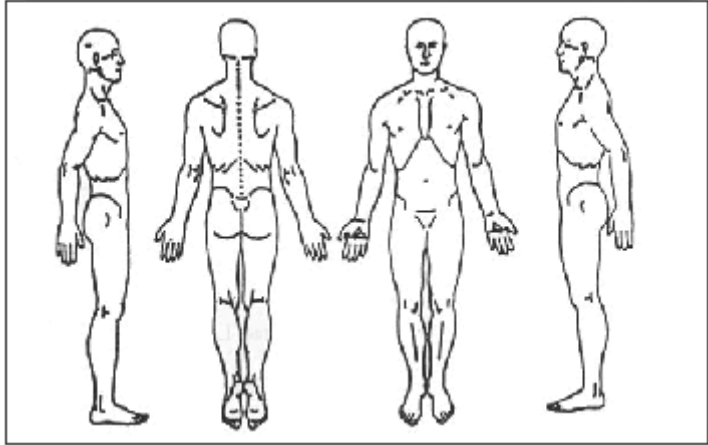
.....

Have you ever had any falls, broken bones or other injuries, childhood accidents, motor vehicle accidents?

.....

Do you have a family history of: Arthritis Cancer Diabetes Heart Disease
 Nervous system disorder Muscular disorder

Signature Date



Pain scale- please mark

No Worst

Pain 0 10 Pain

