

*Welcome to*

# paradechiropractic

## **Your Personal Details**

Name: (Mr/Mrs/Ms/Miss/Dr) \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Are you covered by private health insurance?  Yes  No Company: \_\_\_\_\_Do you have a Pension/DVA/Health Care Card?  Yes  No Number: \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Have you ever seen a chiropractor before?  Yes  No Dr \_\_\_\_\_

## **Your Health History**

I would like help with: \_\_\_\_\_

Was this caused by: Motor Vehicle Accident \_\_\_\_\_ Work Injury \_\_\_\_\_ Other Accident \_\_\_\_\_

What treatment have you already received for this condition? \_\_\_\_\_

How effective was this treatment? \_\_\_\_\_

Do you have any other health complaints: \_\_\_\_\_

Have you currently or previously been diagnosed with any of the following? (please tick)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Multiple Sclerosis     |
| <input type="checkbox"/> Anaemia                              | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Paget's disease        |
| <input type="checkbox"/> Artificial joints/metal pins/fusions | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Pregnancy (____weeks)  |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Heart Conditions  | <input type="checkbox"/> Prostate problems      |
| <input type="checkbox"/> Blood Pressure – High/Low            | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Skin Disorders         |
| <input type="checkbox"/> Cancer                               | <input type="checkbox"/> HIV               | <input type="checkbox"/> Spinal Injuries        |
| <input type="checkbox"/> Circulation Problems                 | <input type="checkbox"/> Kidney conditions | <input type="checkbox"/> Whiplash               |
| <input type="checkbox"/> Concussion                           |  |   |

Are you seeing any health practitioners for anything else at the moment? Yes No \_\_\_\_\_Are you currently taking any medication? Yes No \_\_\_\_\_Have you ever been in a car or motor bike accident? Yes No Please describe + year: \_\_\_\_\_

Any other accidents (falls, etc) + date: \_\_\_\_\_

Please list &amp; date any previous:

Fractures \_\_\_\_\_

Operations \_\_\_\_\_

Please sign \_\_\_\_\_ Date: \_\_\_\_\_