livingwell CHIROPRACTIC

Chancellor Park Shopping Village
Cnr University Way & Scholars Way
Sippy Downs, QLD 4556
Phone: 07 5456 1911

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date:_____

Surname:	First Name: Preferred Name:	
Address:	Town/Suburb:	
	Post Code:	
Home Ph:	Mob Ph:	Work Ph:
Birth Date:	Email:	
Occupation:	Employed By:	
Type of work: □ Sitting □ Computer □ Standing □ Driving □ Lifting □ Other _____		
Spouse's name:		
Children's names & ages:		
Do you have private health insurance? Yes/No If yes, which fund?_____		
Whom may we thank for referring you to our practice?		

Please list your chief complaints in order of severity,
or tick here if your reason for attending is to improve Health and Wellness □

1. _____ for how long? _____
2. _____ for how long? _____
3. _____ for how long? _____

Where is the main problem? _____

Is the pain □ Sharp □ Dull □ Stabbing □ Burning □ Throbbing □ Like pins & needles

Does the pain spread? □ Yes □ No If yes, to where? _____

Do you have numbness? □ Yes □ No If yes, where? _____

Is there pain when you cough or sneeze? □ Yes □ No If yes, where? _____

Is there pain when you sit or stand? □ Yes □ No If yes, where? _____

Is the pain getting progressively worse? □ Yes □ No □ Constant □ Comes & goes

Do you have headaches? □ Yes □ No If yes, tick all that apply:

□ Tension □ Throbbing □ Sinus □ Migraine □ Other: _____

Indicate any function below that aggravates or are aggravated by your condition (please tick all that apply):

□ Walking □ Steep climbing □ Driving □ Working □ Recreation □ Bowel movements

□ Digestion □ Vision □ Sinuses □ Hearing □ Smelling □ Sleep

□ Reproductive Organs (i.e. menstruation, prostrate)

Have you ever been to a chiropractor before? □ Yes □ No If yes, when? _____

What do you think is wrong? _____

What do you think caused the problem? _____

Please list any operations you have had:

1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had:

1. _____ 2. _____ 3. _____

Date of last physical: _____/_____/_____

Is there any chance that you are pregnant? □ Yes □ No

Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind? _____

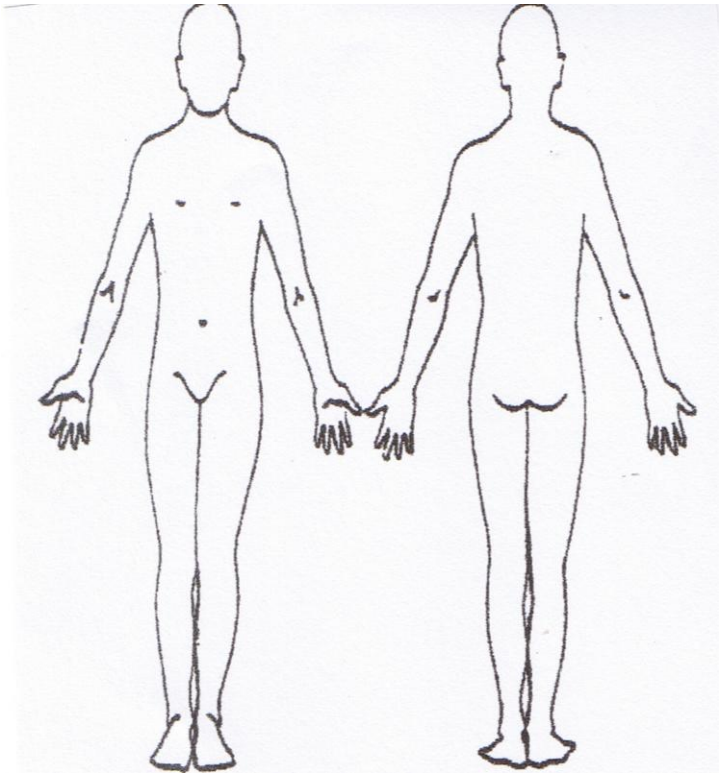
Medication you currently take: _____

Does your father, mother, sister or children have similar problems? □ Yes □ No If yes, who? _____

Please mark the areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
+ + + + +	o o o o o	x x x x x	z z z z z	/ / / / / / /
+ + + + +	o o o o o	x x x x x	z z z z z	/ / / / / / /

PAIN CHART:



Neck/Shoulder/Arm Pain
On a scale of zero to ten, I rate my discomfort as follows:
(_____)
0 (no pain) (sever pain) 10

Mid Back Pain
On a scale of zero to ten, I rate my discomfort as follows:
(_____)
0 (no pain) (sever pain) 10

Low Back and Leg Pain
On a scale of zero to ten, I rate my discomfort as follows:
(_____)
0 (no pain) (sever pain) 10

When the pain is at its worst, how does it feel? _____

_____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
□ Moody	□ Decision making	□ Lose patience with your family
□ Irritable	□ Poor attitude	□ Restricted household duties
□ Interrupt sleep	□ Decreased productivity	□ Can't exercise or play sport
□ Restrict your daily activities	□ Exhausted at end of the day	□ Interference with hobbies/activities

PATIENT SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____ DATE: _____