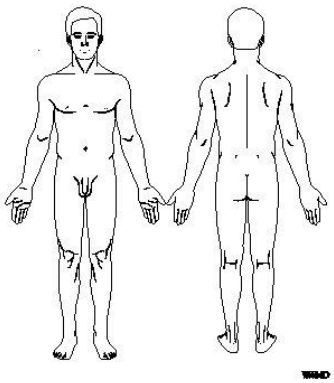
Confidential Patient Case History

Welcome to Wheaton Chiropractic. Your answers to this health questionnaire will help us to determine if chiropractic can help you and enable us to devise the most effective treatment plan if yours is a chiropractic case. Thank you.

NAME : _____ DATE :_____
ADDRESS : _____ POST CODE :_____
PHONE : (Home) _____(Work) _____(Mobile) :_____
E-mail : _____ D.O.B :_____ Age : _____
Occupation : _____ Marital Status : _____ No of Children : _____

I have been referred to this office by Mr /Mrs /Dr : _____
Family ☐ Friend ☐ Sign ☐ Telephone Directory ☐ Other ☐
Have you had previous Chiropractic Care? Yes/ No.
Name of Chiropractor : _____ Date of last chiropractic care : _____
Name of your usual medical doctor:_____
When was your last medical check-up : _____
Have you had x-rays taken of your spine? Yes / No If yes, when and where : _____
_____
What is your major complaint today? _____
What do you think caused this complaint? _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? Yes/No
What aggravates your condition? _____
Is your pain:Sharp / Dull / Shooting / Constant / Comes and goes / Progressively worsening?(Please circle)
Is this condition interfering with your : Work / Sleep / Daily Routine / Other _____
Have you had any other treatment for this condition? Yes / No. If yes, what and when _____
_____

PLEASE ILLUSTRATE AFFECTED AREAS



Are there any other problems you are concerned with? _____
Have you ever been in an accident? Yes / No. Work / Motor Vehicle / Other _____
Nature of the accident : _____ When was the accident? : _____
Is this a WorkCover or TAC Claim? Yes / No Claim number : _____

Have you ever had a knock or fall? If yes, please comment _____
Please list any medications or vitamins you are taking and for what condition : _____
_____
Have you ever had surgery? Yes /No. If yes, what for and when : _____
_____
Do you sleep on your : Side / Back / Stomach? (Please circle)
Do you wear : Heel Lifts / Sole Lifts / Inner Soles / Arch Supports ? (Please circle)

HAVE YOU EVER :	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had high or low Blood Pressure?	☐	☐	_____
Suffered a stroke or stroke-like symptoms?	☐	☐	_____
Experienced numbness anywhere?	☐	☐	_____
Experienced pins and needles anywhere?	☐	☐	_____

PLEASE PLACE A VERTICAL MARK ON THE LINE AT THE POINT THAT BEST REPRESENTS YOUR ANSWER :

Are you suffering from stress?	0 _____	10
	None	Extreme
Do you have a healthy diet?	0 _____	10
	Terrible	Excellent
Where do you rate your pain level at the moment?	0 _____	10
	No pain at all	Worst possible pain
How would you rate your energy levels?	0 _____	10
	No energy	Full of energy
How committed are you to achieving optimal health?	0 _____	10
	No commitment	Total Commitment

HABITS : (Please Tick)

	Heavy	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

For women only :
Do you use birth control pill? _____
If yes, for how long? _____
Is there any chance you may be pregnant? Yes / No

FAMILY HEALTH INFORMATION :
Has anyone in your immediate family (including aunts, uncles and grandparents) had any of the following?

☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Thyroid disease ☐ Other

Please Explain :

_____

My private health insurance is with _____ Covers Chiropractic? Yes / No

I understand that no accounts are rendered by this centre and my payment at the time of first visit will be:

☐ Cash ☐ Credit Card ☐ EFTPOS ☐ Cheque

Signed : _____ Print Name : _____