

Point Cook Chiropractic Health & Wellness Centre
Confidential Client Information

Please Print Clearly and Complete All Information

Date: _____

Name: Mr / Mrs / Miss / Ms / Dr _____

Address: _____ P/Code: _____

Phone: (H): _____ (M): _____ (W): _____ Email: _____

DOB: _____ Age: _____ Male / Female (please circle) Spouse's Name: _____ No. of Children: _____

Children's Name(s) & Age(s):	Previous Chiropractic Care?
Name: _____ Age: _____	Yes/No: _____ Reason/s: _____
Name: _____ Age: _____	Yes/No: _____ Reason/s: _____
Name: _____ Age: _____	Yes/No: _____ Reason/s: _____

Your Occupation: _____ Employer: _____ I'm Self-employed

Who can we thank for referring you to our office? Directory Google Website GP/Physio/Chiro Family/Friend _____

Have you had Chiropractic Care before? Y / N (circle). If yes, Name/Location of Chiropractor/Practice: _____

Date of last visit: _____ Reason/s for stopping care: _____

What is/are the most important reason(s) you are attending our office today?

.....

I am also concerned about:

This condition started: DaysWeeksMonthsYears ago, and it is: getting worse getting better staying the same

This condition: is aggravated by:, and improved by:

What do you think is wrong?: What do you think is the Cause?

What has been affected because of this? Tick all applicable

Home Work Sleep Exercise Stress levels Emotion/Temper Digestion Toilet habits Other

Do any other member(s) of your family suffer or have suffered from this condition? Yes / No

Lifestyle: Your current and past activities and habits (How you Think, Move and Eat) contribute to your current health status and the health challenges that you face today, can dictate how you respond to any Chiropractic care, and influence how you fare in the future.

What Spinal Maintenance program were you given when you were growing up?

How would you rate your Health Status today, out of 10? (10 = best)/10

Exercise: How do you keep fit? (eg. Gym, run, swim, etc.) How often would you exercise per week?

What sports have you played in the past?

What do you do to relax/reduce stress?

Sleep: Do you have any trouble: a) getting to sleep? Yes / No, b) staying asleep? Yes / No, Are you getting enough sleep? Yes / No

How many hours on average?hours

Diet: Are you Vegetarian? Yes No

Accident & Trauma History (Please circle)

Past accidents & traumas can contribute to your current condition and your symptoms today.

Was your birth difficult?	Yes / No
Were forceps used in your delivery?	Yes / No
Were you a Caesarean birth?	Yes / No
Was vacuum extraction used?	Yes / No

Have you had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Driver |
| <input type="checkbox"/> Car | <input type="checkbox"/> Passenger |
| <input type="checkbox"/> Motorbike | <input type="checkbox"/> Pedestrian |
| <input type="checkbox"/> Bicycle falls | <input type="checkbox"/> Sporting injuries |
| <input type="checkbox"/> Childhood slips or falls | <input type="checkbox"/> Falls ladders/stairs |
| <input type="checkbox"/> Horse falls | <input type="checkbox"/> Repetitive strain injuries |
| <input type="checkbox"/> Fractures / Dislocations | |

General Health Questions:

What medical conditions have you had or currently suffering from?

Have you had any previous surgery? _____

Are you taking any medications? Yes / No (please list)

Are you taking any vitamins/supplements? Y/ N (please list)

Are you a smoker? Yes / No If yes, how many per day: _____

Has anyone in your family (incl Aunts, Uncles, Grandparents) had any of the following?

Heart disease _____ Arthritis _____

Thyroid Disease (Goitre) _____ Diabetes _____

Cancer

How do you rate your Stress Level? 1-10, 10 being the highest.

Physical : _____ Emotional: _____ Chemical: _____

What do you think is the major cause of your stress? (eg. Work, Study, Family, etc.)
