

# 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): \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female (please circle) Email: \_\_\_\_\_

Spouse / Partner's Name: \_\_\_\_\_ No. of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  I'm Self-employed

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

Have you had Chiropractic Care before? Y / N (circle). If yes, name of chiropractor and date of last visit: \_\_\_\_\_

**Are you visiting our office for Wellness or a Specific Health Condition? (Please Circle) Please list your Complaints below:**

\_\_\_\_\_ When did it start? \_\_\_\_\_ Have you had this before? If so, when: \_\_\_\_\_

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Have you seen any health professionals for your condition? Yes / No (please circle) If Yes, please list their profession and their diagnosis below:

\_\_\_\_\_ Diagnosis: \_\_\_\_\_ Has it helped? Yes / No

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What do You think is wrong? \_\_\_\_\_ What do You think is the Cause? \_\_\_\_\_

What activities make it worse?: \_\_\_\_\_ What makes it better?: \_\_\_\_\_

What steps have you taken so far to address the cause? Ice Heat Stretch Massage Rest Painkillers Other: \_\_\_\_\_

What activities have been affected because of this? Home Work Personal \_\_\_\_\_

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

**Accident & Trauma History (Please circle)**

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

Past accidents & traumas can contribute to your current condition and your symptoms today. Have you had any of the following:

- Motor Vehicle Accident
- Car  Driver
  - Motorbike  Passenger
  - Pedestrian

- Bicycle falls
- Sporting injuries
- Childhood slips or falls
- Falls off ladders and/or stairs
- Horse falls
- Repetitive strain injuries
- Work-related stress (PC, Desk Work)
- 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)

\_\_\_\_\_

Do you have any ongoing health problems? Yes / No

Are you a smoker? Yes / No

Have you had any unexplained weight loss? Yes / No

Have you had any abnormal bleeding from any body part? Yes / No

Have you had any recent changes to a mole or a freckle? Yes / No

Do you have any unusual lumps or swellings? Yes / No

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

Heart disease \_\_\_\_\_  Arthritis \_\_\_\_\_

Thyroid Disease(Goitre ) \_\_\_\_\_  Diabetes \_\_\_\_\_

Cancer

**Lifestyle:** Your current and past activities may contribute to your current conditions and symptoms today.

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

**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

Are you Vegetarian? Yes No

**SYSTEMS REVIEW HISTORY**

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of your condition. Please **tick the appropriate box** if you have had or are suffering from the following health conditions. Leave blank any that do not apply.

**O = Occasionally, F = Frequently, C = Constantly**

| O                        | F                        | C                        |                               | O                        | F                        | C                        |                           | O                        | F                        | C                        |                               | O                        | F                        | C                        |                         |
|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Head</b>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Genito-Urinary System</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>General Symptoms</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tightness around Chest    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Balance               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Racing Heart              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty starting urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thumping Heart            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dribbling urination           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears               |                          |                          |                          |                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leakage                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Buzzing in Ears               |                          |                          |                          | <b>Stomach</b>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed Wetting                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood swings                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous stomach           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Fatigue       |
|                          |                          |                          | <b>Neck</b>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Belching/Excessive Wind   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Energy Loss             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate trouble              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fevers                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ache                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloatedness               |                          |                          |                          | <b>Females Only</b>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sleep           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soreness/Stiffness            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful periods               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clicking                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Pain              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful/Tender Breasts        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression              |
|                          |                          |                          | <b>Shoulders/Arms/Fingers</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder pain         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumps in Breasts              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Sweating      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Menstrual Flow      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tremors                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pins & Needles                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Minimal Menstrual Flow        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor Circulation        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhoea                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restricted Movement           |                          |                          |                          | Irregular Bowel Movements | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding between periods      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Low Back/Legs/Feet</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flushes                   |                          |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Strength              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menopausal Symptoms           |                          |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold/Hot Hands                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pins & Needles            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Discharge             |                          |                          |                          |                         |
|                          |                          |                          | <b>Chest</b>                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful Intercourse           |                          |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restricted Movement       |                          |                          |                          |                               |                          |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain around Ribs              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold/Hot Feet             |                          |                          |                          |                               |                          |                          |                          |                         |
|                          |                          |                          |                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints            |                          |                          |                          |                               |                          |                          |                          |                         |

**Health Status:** Using the 0 – 10 scale below, 10 being Excellent health, please circle what you believe to be your current state of health.

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
 Very Poor      Poor      Average      Good      Excellent

**What steps do you think you could take to improve your health?** (eg. More rest, stop smoking/drinking, eating better, etc.) \_\_\_\_\_

**Wellness Commitment:** At **Point Cook Chiropractic** we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We *do not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% — 20% — 30% — 40% — 50% — 60% — 70% — 80% — 90% — 100%

Please note that any and all information, written or otherwise, that you provide is strictly confidential and is so treated by the entire staff. No information or records will be released to any person (health practitioner or otherwise), health fund, or insurance company without the written permission of the patient.

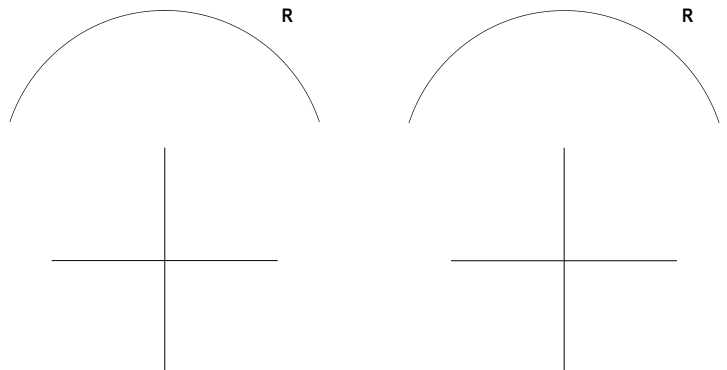
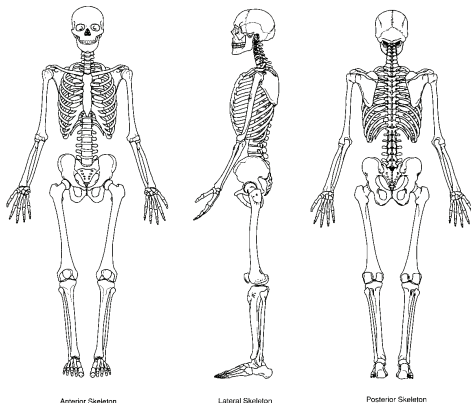
**I believe the information above is correct to the best of my knowledge.**

**Patient's Signature:** \_\_\_\_\_

**Date:**    /    /

**Doctor's Notes**

**ROM:**



**BWS:**      L: \_\_\_\_\_ kg      R: \_\_\_\_\_ kg

**Handedness:**    L    R

**Cx:**

**Lx:**