

Ther:

Type:

NP Date:

Scanned
Cliniko

Wellbeing CHIROPRACTIC

PT ID:

PERSONAL DETAILS:

***CONFIDENTIAL

Full Name:		Date Of Birth:	
Address:		Suburb & Postcode:	
Mobile/Home #:		Occupation:	
Spouse / Partner Name:		No. Children:	
Email Address:			
Private Insurance Massage Cover	Y / N		
Emergency Contact:		Emergency's Phone #	
How did you find us? (please circle)	Facebook	Google	Passing By
	Festival/Show	GP Doctor	
	Who Referred You:		
Rate your POSTURE out of 10? (10-1, Excellent - Poor)	Height (cm):	Weight (kg):	

MEDICAL & GENERAL HEALTH HISTORY:

Are you PREGNANT?	
List current MEDICATIONS	
Any personal history of serious disease?	
Please list SURGERIES (incl. yr)	

STRESSES

Physical (falls, accidents, work posture) =
Bio-chemical (smoke, diet, drugs/alcohol) =
Psychological, Emotional (work, financial, relationship stresses) =

GENERAL SYSTEM REVIEW

(Tick Left box = Past symptoms, Right box = Current symptoms)

- | | | |
|---|--|---|
| <input type="checkbox"/> Pins & Needles, Numbness, Weakness | <input type="checkbox"/> Knee/Foot/Ankle trouble | <input type="checkbox"/> Asthma/Coughing |
| <input type="checkbox"/> Soreness in Neck | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Ear Disorders |
| <input type="checkbox"/> Dizziness/Light-headed/Vision problems | <input type="checkbox"/> Leg/Muscle Cramps | <input type="checkbox"/> Freq loose stools |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arm/Elbow/Wrist/Hand Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Painful/Clicking Jaw | <input type="checkbox"/> Stroke (TIA) | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Shoulder Pain/Stiffness/Tension | <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Menstrual issues |
| <input type="checkbox"/> Mid Back Pain/Tension | <input type="checkbox"/> Allergies, Colds & Flu | <input type="checkbox"/> Diarrhoea/Digestion |
| <input type="checkbox"/> Pain in Ribs or Chest | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Low Back Pain/Weakness/Stiffness | <input type="checkbox"/> Loss of Grip | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Hip Pain/Stiffness, Buttock & Leg Pain | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Drink Alcohol(/ wk) |
| <input type="checkbox"/> Pain on Straining/Coughing/Sneezing | <input type="checkbox"/> Smoker (___/day) | |
| <input type="checkbox"/> Diabetes, kidney disease or heart disease | | |
| <input type="checkbox"/> Medical devices and implanted devices such as intra-cranial aneurysm clips, cardiac pacemaker, coronary stents, intraocular foreign bodies and cochlear implants (circle relevant) | | |

REASON FOR YOUR VISIT :

List COMPLAINTS	When did this BEGIN?	SEVERITY? Mild=1 Severe=10	HOW did this begin?	Have you had this BEFORE?	What makes this complaint WORSE?	What other TREATMENT have you had for this?
1.						
2.						
3.						

OFFICE USE ONLY:

NOTES

Y / N HEADACHES

Y / N DIZZINESS/NAUSEA

Y / N BLURRED VISION

Y / N OTHER N,W,T

Y / N RECENT TRAUMA

Y / N OTHER HOSPITALISATIONS

Y / N OTHER MEDICATION

NOTES:

GOALS: