Required for Your Case History File: All Information Is Confidential

Full Legal Name_____ Name you prefer_____

Home Address_____

Suburb_____ State_____ Postcode _____

Telephone (Mobile) _____ Telephone (Work) _____

Email _____ Referred by_____

Occupation_____ Employer_____

Name of Spouse_____Number of Children_____

Emergency Contact _____Telephone_____

Age_____ Date of Birth _____ Gender _____ Years of Education_____

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes ❑ No ❑ If yes, who? _____

Who is your general practitioner? _____
Date of Last Physical Examination_____

Have you been treated for any health condition by a physician in the last year? Yes ❑ No ❑

What medications/vitamins/herbs are you taking?_____
_____
_____Are you allergic to any medications? Yes ❑ No ❑

Previous serious illness/ hospitalization: (Please date & describe) _____
_____

Have ever had: Surgery Yes ❑ No ❑ Fractures Yes ❑ No ❑ Car Accidents Yes ❑ No ❑
Falls Yes ❑ No ❑ On-Job Injury Yes ❑ No ❑

Family history of: Heart disease Yes ❑ No ❑ Cancer Yes ❑ No ❑ Diabetes Yes ❑ No ❑

If you are female, are you possibly pregnant? Yes ❑ No ❑ Date of last menstrual period ____

Primary Symptom/Problem for this visit _____
_____

Have you been prescribed an opioid for your primary problem? Yes ❒ No ❒
Have you had a previous surgery for your primary problem? Yes ❒ No ❒
Are you considering surgery for your primary problem? Yes ❒ No ❒
Have you had a previous steroid injection for your primary problem? Yes ❒ No ❒
Are you considering a steroid injection for your primary problem? Yes ❒ No ❒

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant ❑ Intermittent ❑ Is your condition getting? Worse ❑ Better ❑ Same ❑

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? Yes ❑ No ❑ sleep? Yes ❑ No ❑ routine? Yes ❑ No ❑

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Check if you have had any of the following symptoms in the last <u>30 days</u>:

Pain worse at night ❑ Constant pain unrelated to motion ❑ Unexplained weight loss ❑
Loss of bowel or bladder control ❑ Bacterial infection ❑ Surgery ❑ Fever or chills ❑

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

In accordance with the Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between practitioners within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Signature _____Date _____form 105 a