A BIG HELLO FROM CHIROPRACTIC CENTRAL!

- Name: (per your Medicare Card): _____
- Medicare card number: _____ Ref#: _____ Expiry: _____
- Residential address: _____
- Email: _____
- Mobile # _____ Home # _____ Work # _____
- D.O.B: ____/____/____ Occupation: _____ Employer: _____
- Name of health fund: _____
- Marital status: _____ Partner's name: _____
- Names & ages of any children: _____
- How were you introduced to our office? _____

- **Please list your primary concerns and rate the severity of your conditions (0=least, 10=severe)**

1. _____
2. _____
3. _____

- **Subluxation can affect nerves to different parts of your body. Please circle any conditions experienced in the last** 12 months.

Insomnia	Allergies	Frequent colds	Thrush	IBS
Fatigue	Sinus trouble	Period pains	Hot flushes	Crohns
Depression	Liver problems	Loss of strength	Cholesterol	Colitis
Headaches	Stomach pain	Loss of balance	Blood pressure	Loose bowels
Migraines	Poor circulation	Emphysema	Hearing loss	Constipation
Dizziness	Swollen joints	Asthma	Ringing in ears	Tightness
Light headedness	Pins & needles	Whooping cough	Pain around ribs	Spinal pain
Nausea	Numbness	Tumors / growths	Belching or excessive wind	Sore feet

- **Please circle any family history / previous conditions**

HIV / AIDS	Cancer	Fibromyalgia	Heart disease	Gout
Hepatitis	Bronchitis	CFS	MS	Tonsillitis
STD	Epilepsy	Psychiatric care	Kidney disease	Glaucoma
Arthritis	Chicken pox	Ulcers	Pacemaker	Cataract
Rheumatoid arthritis	Mumps	PMS	Alcohol/drug addiction	Polio
Appendicitis	Measles	Eating disorder/s	Stroke	Hot flushes
CTS	Miscarriage	Cochlear implant/s	Intra-ocular foreign bodies	Spinal surgery
Hernia	Pneumonia	Parkinson's	Liver disease	Herniated disc
Osteoporosis	Diabetes	Alzheimer's	Anemia	Coronary stents

- List all medications taken: _____
- List all supplements taken: _____
- Have you ever been diagnosed with cancer? YES NO
- If yes, when, where & what type? _____
- Any chance you are pregnant? _____
- Are you breastfeeding? _____
- Describe your stress level? _____
- Are you a regular smoker? YES NO # per day? _____
- Briefly describe any slips, falls, traumas, accidents including broken bones and / or reconstructions. Include the year of event. _____

_____

- **Indicate any vehicular accidents you have had including any "minor" accidents / incidents.**

Type of vehicle	Year/s of accident/s	Rear/ front or side collision	Speed	Injuries	Seatbelt	Treatm't received
Motor vehicle						
Water vehicle						
Animal accident						
Bike accident						
Other						

- Are there any cultural, psychological or social practices we need to be aware of relating to the provision of your
- chiropractic care? _____
- Are you as healthy and happy as you want to be? _____
- What goals are you most interested in?

0 Improving my overall health
0 Eliminating my pain and / or symptoms
0 Responding better to stress
0 Learning about and preparing for healthy pre-conception, pregnancy and birth
0 Increasing my energy and vitality
0 Increasing the strength of my spine & correcting my posture
0 Learning natural strategies to elevate my health & longevity
0 Boosting my immune system
0 Recovery from strenuous exercise and activity
0 Change my body composition (lose / gain weight, toning)
0 Leading my loved ones to a healthier lifestyle
0 Being happier & healthier
0 Keeping my nervous system functioning at an optimal level
0 Other:

I hereby authorise the Chiropractor and / or the delegates of the Chiropractor to perform any necessary diagnostic procedures, including x-ray to fully evaluate my condition for the presence of vertebral subluxation. Any proposed diagnostic imaging procedures have been explained to me in full and I have had the opportunity to ask questions.

- Patient signature: _____
- Date: _____

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Chiropractic Central

Office Use

Name	DOB	Address	Gender	Record Number