Patient Number: _____ Date:_____

McMillan Chiropractic Centre

Thank you for allowing us to be involved in the improvement of your Health & Wellbeing!

It is *essential* that you complete all the following questions to the best of your ability. These questions are all relevant to your health & our proposed Chiropractic Care Plan. Failing to provide information at this point could affect your ability to respond to treatment & even place your health at risk from inappropriate treatment being provided.

Your Details:

DR/MR/MRS/MS/MISS [Full Name]: _____ Date of Birth____/____/_____

Marital Status: (please circle) Single/Defacto/Married/Divorced/Widowed/Other Children: _____

Residential Address: _____

Postal Address: _____

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

Which is your preferred contact number? _____ Would you prefer SMS or Phone CALL reminders? SMS / CALL

E-mail: _____ Would you like to receive email updates? YES / NO

Do you have a concession card? YES / NO Occupation: _____

Whom may we thank for referring you to us? _____

Next of Kin: _____ Relationship to you: _____ Contact:_____

Have you had Chiropractic Care before? YES / NO - With whom? _____ Last Visit: _____

Who is your GP: _____ Contact: _____ Last Visit: _____

You're Health Profile

For Postural Assessment, please tell us the following: Height _____ Weight _____

What is your presenting complaint? _____

When did this problem begin? _____

How did it begin? _____

What makes it better? _____

What makes it worse? _____

Have you had it before: YES / NO – How many times: _____ When was the last time? _____

What caused the problem in the past: _____

Is the problem stopping you from doing anything? YES / NO – if so, please list: _____

Have you seen anyone else about this problem? YES / NO – if so, whom & what was the outcome: _____

List **ALL** medication or vitamins you are taking and what they are for: _____

List **ALL** Operations, Surgical Procedures, major tests you have had, with dates:

_____

List **ALL** past accidents, injuries, broken bones you have had, with dates:

_____

List **ALL** past X-rays, CT's, MRI's you have had, where and when?

_____

Do you Exercise regularly? YES / NO - if so, what type & how often:

_____

Do you smoke? YES / NO – Do you Drink Alcohol? YES / NO – if so, how much & how often?

_____

Do you take or have you ever taken recreational drugs? YES / NO – if so, what?

_____

Family History

Have any family members suffered from:

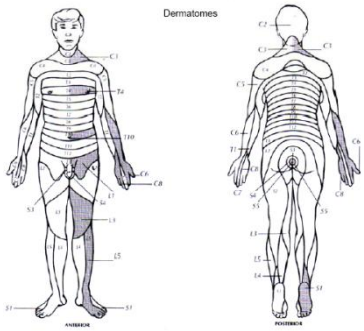
Heart Disease	YES / NO, who? _____	Cancer	YES / NO, who? _____
Stroke	YES / NO, who? _____	Inflammatory Arthritis	YES / NO, who? _____

Are there any other significant health concerns? _____

Please indicate on the following diagram where you feel your discomfort utilising the symbols provided.

Scale

A = Aching Pain
B = Burning Pain
S = Stabbing Pain
N = Numbness
P = Pins & Needles



Please indicate on the following scale how you are feeling at the moment: (1 being WORST ever felt, 10 being BEST ever felt)

	WORST									BEST
Presenting Symptoms	1	2	3	4	5	6	7	8	9	10
Pain Level	1	2	3	4	5	6	7	8	9	10
General Wellbeing	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
Energy Levels	1	2	3	4	5	6	7	8	9	10

Please tick if you have suffered any of the following recently or on a regular basis:

Dizziness		Unexplained Weight Loss		Headaches	
Fainting		High Blood Pressure		Migraines	
Difficulty Swallowing		Fatigue		Back Pain	
Visual Problems		Sleeping Problems		Loss of Balance	
Nausea		Depression		Stomach Problems	
Numbness		Loss of Smell		Heartburn	
Pins & Needles		Buzzing / Ringing ears		Ulcers	
Difficulty Talking		Neck Pain / Stiffness		Menstrual Problems	
Night Sweats		Constipation		Hot Flushes	
Inflammatory Arthritis		Diarrhoea		Frequent Coughs / Colds	
Asthma		Allergies		Frequent Ear Infections	
Scoliosis		Seizures		Tonsillitis	