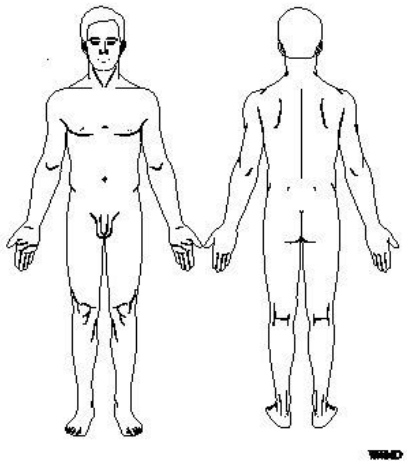
# Confidential Patient Case History

Welcome to Wheaton Chiropractic. Your answers to this health questionnaire will help us to determine if chiropractic can help you and enable us to devise the most effective treatment plan if yours is a chiropractic case. Thank you.

NAME : _____ DATE :_____
PARENT / GUARDIAN :_____
ADDRESS : _____ POST CODE :_____
PHONE : (Home) _____(Work) _____(Mobile) :_____
E-mail : _____ D.O.B :_____ Age : _____

I have been referred to this office by Mr /Mrs /Dr : _____
Family ☐ Friend ☐ Sign ☐ Telephone Directory ☐ Other ☐
Have you had previous Chiropractic Care? Yes/ No.
Name of Chiropractor : _____ Date of last chiropractic care : _____
Have you had x-rays taken of your spine? Yes / No If yes, when and where : _____
_____
What is your major complaint today? _____
What do you think caused this complaint? _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? Yes/No
What aggravates your condition? _____
Is your pain :Sharp / Dull / Shooting / Constant / Comes and goes / Progressively worsening?(Please circle)
Is this condition interfering with your : Work / Sleep / Daily Routine / Other _____
Have you had any other treatment for this condition? Yes / No. If yes, what and when _____
_____

PLEASE ILLUSTRATE AFFECTED AREAS



Are there any other problems you are concerned with? _____
Have you ever been in an accident? Yes / No. Work / Motor Vehicle / Other _____
Nature of the accident : _____ When was the accident? : _____
Have you ever had a knock or fall? If yes, please comment _____
Please list any medications or vitamins you are taking and for what condition : _____
_____

Have you ever been hospitalized or had surgery? Yes /No. If yes, what for and when : _____
_____
_____
Vaccination History? _____
Have you had any diseases / illnesses? Yes / No
Have you ever had any broken bones or sprain injuries? Yes / No If yes, please detail:
_____
_____
Have you ever been assessed for the presence of scoliosis? Yes / No
Do you have a learning disorder? Yes / No
How many times have you taken antibiotics? In last six months _____ During lifetime _____
How many doses of Prescription Medication have you taken? In last six months _____ During lifetime _____

Do you sleep on your : Side / Back / Stomach? (Please circle)
Do you wear : Heel Lifts / Sole Lifts / Inner Soles / Arch Supports ? (Please circle)

Please in indicate by circling any of the following conditions which you have experienced in the past:

| | | | |
|---|---|---|---|
| Headache | Neck Pain | Back Pain | Allergies |
| Constipation/Diarrhoea | Earaches/Infections | Sinus Pain | Recurrent Tonsillitis |
| Bedwetting | Recurrent Chest Infections | Growing Pains | Hyperactivity |
| Loss of appetite | Poor sleeping habits | Visual disorders | Constant fatigue |
| Arm/Leg Pain | Poor co-ordination | Learning difficulties | Recurrent Stomach aches |
| Digestive disorders | Scoliosis | Fever | Convulsions |
| Joint Pains | Asthma | Travel sickness | Night terrors |
| Seizures | Chronic colds | Recurring fevers | Hip problems |

Other : _____

**FAMILY HEALTH INFORMATION :**
Has anyone in your immediate family (including aunts, uncles and grandparents) had any of the following?
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Thyroid disease ☐ Other

Please Explain :

_____

My private health insurance is with _____ Covers Chiropractic? Yes / No

I understand that no accounts are rendered by this centre and my payment at the time of first visit will be:

☐ Cash ☐ Credit Card ☐ EFTPOS ☐ Cheque

Signed : _____ Print Name : _____