SURNAME_____NAME_____ MIDDLE NAME _____DATE ___/____/____

WHO RECOMMENDED YOU TO THIS CLINIC? _____

YOUR FULL ADDRESS_____

_____POST CODE _____

HOME PHONE _____WORK PHONE _____MOBILE PHONE _____

EMAIL_____ IF YOU DO NOT WISH TO BE CONTACTED BY EMAIL, PLEASE TICK BOX ❑

AGE _____ BIRTHDATE ____/____/____ SEX MALE ❑ FEMALE ❑ MARRIED ❑ SINGLE ❑ No. CHILDREN _____

OCCUPATION_____EMPLOYER_____

ARE YOU IN A HEALTH FUND WHICH COVERS CHIROPRACTIC CARE? YES ❑ NO ❑

IF YES, WHICH FUND?_____ PATIENT REFERENCE NUMBER ON CARD_____

Chiropractic Health Questionnaire

Symptoms related to the Nervous System

The nervous system's function is to control and co-ordinate all the other organs and structures. SPINAL FAULTS may interfere with this function and thus cause a wider variety of symptoms.

Chiropractic deals with the relationship between your spine and your nervous system.

Have you suffered from any of the following (Tick appropriate box):

Past	Present		Past	Present		Past	Present	
❑	❑	Eye Pain	❑	❑	Menstrual Disorders	❑	❑	Pins & Needles of Legs
❑	❑	Headaches	❑	❑	Sexual Disorder	❑	❑	Knee Trouble
❑	❑	Stroke	❑	❑	Chronic Fatigue Syndrome	❑	❑	Foot or Ankle Trouble
❑	❑	Nervousness	❑	❑	Sleeping Problems	❑	❑	Pins & Needles of Feet
❑	❑	Insomnia	❑	❑	Jaw/TMJ Problems	❑	❑	Osteoporosis
❑	❑	Dizziness	❑	❑	Soreness in Neck	❑	❑	Arthritis
❑	❑	Sinus Trouble	❑	❑	Shoulder Pain/Stiffness	❑	❑	Diabetes
❑	❑	Ear Disorders	❑	❑	Arm Pain/Weakness	❑	❑	High Blood Pressure
❑	❑	Hay Fever	❑	❑	Elbow Pain	❑	❑	Chronic Tension/Stress
❑	❑	Recurrent Sore Throats	❑	❑	Pins & Needles of Hands	❑	❑	Loss of Taste
❑	❑	Asthma	❑	❑	Loss of Grip	❑	❑	Significant weight loss/ gain in short time period
❑	❑	Chronic Cough	❑	❑	Wrist or Hand Pain			
❑	❑	Indigestion/Reflux	❑	❑	Mid Back Pain/Stiffness			
❑	❑	Nausea/Vomiting	❑	❑	Pain in Ribs			
❑	❑	Allergies	❑	❑	Low Back Pain/Stiffness			
❑	❑	Constipation	❑	❑	Hip Pain or Stiffness			
❑	❑	Abdominal Pain	❑	❑	Buttock Pain			
❑	❑	Irritable Bowel Syndrome	❑	❑	Leg Pain			
❑	❑	Urinary Disorders	❑	❑	Leg Cramps			
❑	❑	Bed Wetting	❑	❑	Vascular Problem			

Please turn over…

PRESENT SYMPTOMS

What are your present symptoms? _____

Date of Onset: _____

Caused by? _____

Previous treatment by? _____

Result? _____

Has this occurred before and when? _____

Any family history of this problem? YES ❑ NO ❑

Is your major symptom aggravated by, or related to, your work? YES ❑ NO ❑

What medications are you taking and what are they for? (include contraceptives) _____

_____

What serious illness have you had? _____

Do you sleep on Side ❑ Back ❑ Stomach ❑

OTHER

If there is any other relevant information, please describe below:

_____

_____

_____

_____

_____

_____

PREGNANCY

1. Is there any possibility that you might be pregnant? YES ❑ NO ❑
2. Please enter date of the first day of the last menstrual period: _____/_____/_____

SIGNATURE

I, the undersigned, understand this clinic functions on a cash basis and I am financially obligated for any fees, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain re-imbursement from insuring companies. Legal opinion is that X-rays remain the property of the clinic, however, these will be forwarded to suitably qualified practitioners upon their written request.

Signature: _____