

Name: Date of first visit

Address:

Postcode:

Home Tel:

Work Tel:

Mobile:

E-mail:

Occupation

Company

Male Female

Date of Birth

Age Marital Status

Do you have children? How many?

Any grand-children? How many?

How did you hear about us?

I was referred by

Please tick relevant Boxes	DOCTOR:	Doctor's Comments only:
Main area of complaint: Low Back <input type="checkbox"/> Upper Back <input type="checkbox"/> Neck <input type="checkbox"/> Headache <input type="checkbox"/> Shoulder <input type="checkbox"/>		Started: _____ Location: _____
Any past Trauma ie. Car accident/Fall Yes <input type="checkbox"/> No <input type="checkbox"/> When: _____		Radiation: Arm: _____ Leg: _____
Is sleep disturbed: Yes <input type="checkbox"/> No <input type="checkbox"/> Do you get up rested in morning: Yes <input type="checkbox"/> No <input type="checkbox"/>		Attributes: Constant/Intermittent Daily/Variable Worse/Ease/Unchanged Slow (insidious)/Sudden
Any pain in the abdomen/chest Yes <input type="checkbox"/> No <input type="checkbox"/>		Type: Dull Ache/Sharp/Stiff/Throbbing/Burning
Do you have any problem passing water Yes <input type="checkbox"/> No <input type="checkbox"/>		Worse: Morning/Day/Evening/Night
Any change or problems in bowel habits/digestion Yes <input type="checkbox"/> No <input type="checkbox"/>		Previous X-Rays/MRI/Scan _____
Lack of energy <input checked="" type="checkbox"/> 10 Yes <input type="checkbox"/> No <input type="checkbox"/>		
Any present or previous illness/condition/fracture or surgery: Heart disease <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Psoriasis <input type="checkbox"/> Diabetes <input type="checkbox"/> Bone disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological disease <input type="checkbox"/> IBS <input type="checkbox"/> Heartburn <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Any family medical history of: Heart disease <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Psoriasis <input type="checkbox"/> Diabetes <input type="checkbox"/> Bone disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological disease <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/>		Red Flags: _____ _____ _____ _____
What medication/supplements/vitamins are you taking:		Surgery: _____ _____ _____
None <input type="checkbox"/>		
Do you: Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do you Drink <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> How much: _____		Diseases: Stroke/Osteoporosis/Infection/CA/DM/Heart/ _____ _____
Previous treatment: GP <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Osteopath <input type="checkbox"/> Hospital Doctor <input type="checkbox"/> None <input type="checkbox"/>		Medication: _____ _____ _____
I will be claiming on my medical insurance YES <input type="checkbox"/> NO <input type="checkbox"/> COMPANY _____		Other: _____ _____ _____
All the above information is correct and I hereby give my consent to undergo an examination (and treatment if I choose) by a practitioner.		
Signed <input type="text"/>		
Date <input type="text"/>		