Ther: Type: NP Date: Scanned ☐
Cliniko ☐

WELLBEING CHIROPRACTIC

PT ID

PERSONAL DETAILS: ***CONFIDENTIAL

Full Name:		**Date Of Birth:**	
Address:		**Suburb:**	
Mobile/Home #:		**Occupation:**	
Spouse / Partner Name:		**No. Children:**	
Email Address:			
Private Insurance Massage Cover	**Y / N**		
Emergency Contact:		**Emergency's Phone #**	
How did you find us? (please circle)	**Facebook Google Passing By Festival/Show GP Doctor Who Referred You: ……...**		
Rate your POSTURE out of 10? (10–1, Excellent - Poor)	**Height (cm):**	**Weight (kg):**	

MEDICAL & GENERAL HEALTH HISTORY:

Are you PREGNANT?	
List current MEDICATIONS	
Any personal history of serious disease?	
Please list SURGERIES (incl. yr)	

STRESSES

Physical (falls, accidents, work posture) =
Bio-chemical (smoke, diet, drugs/alcohol) =
Psychological, Emotional (work, financial, relationship stresses) =

GENERAL SYSTEM REVIEW

(Tick Left box = Past symptoms, Right box = Current symptoms)

□ □ Pins & Needles, Numbness, Weakness
□ □ Soreness in Neck
□ □ Dizziness/Light-headed/Vision problems
□ □ Headaches
□ □ Painful/Clicking Jaw
□ □ Shoulder Pain/Stiffness/Tension
□ □ Mid Back Pain/Tension
□ □ Pain in Ribs or Chest
□ □ Low Back Pain/Weakness/Stiffness
□ □ Hip Pain/Stiffness, Buttock & Leg Pain
□ □ Pain on Straining/Coughing/Sneezing
□ □ Diabetes, kidney disease or heart disease
□ □ Knee/Foot/Ankle trouble
□ □ Unexplained weight loss
□ □ Leg/Muscle Cramps
□ □ Arm/Elbow/Wrist/Hand Pain
□ □ Stroke (TIA)
□ □ Loss of Smell/Taste
□ □ Allergies, Colds & Flu
□ □ Fatigue
□ □ Loss of Grip
□ □ High/Low Blood Pressure
□ □ Smoker (___/day)
□ □ Asthma/Coughing
□ □ Ear Disorders
□ □ Freq loose stools
□ □ Cancer
□ □ Nausea/Vomiting
□ □ Menstrual issues
□ □ Diarrhoea/Digestion
□ □ Constipation
□ □ Abdominal Pain
□ □ Drink Alcohol(/ wk)
□ □ Medical devices and implanted devices such as intra- cranial aneurysm clips, cardiac pacemaker, coronary stents, intraocular foreign bodies and cochlear implants (circle relevant)

REASON FOR YOUR VISIT :

List COMPLAINTS	When did this BEGIN?	SEVERITY? Mild=1 Severe=10	HOW did this begin?	Have you had this BEFORE?	What makes this complaint WORSE?	What other TREATMENT have you had for this?
1.						
2.						
3.						

OFFICE USE:

NOTES

Y / N HEADACHES

Y / N DIZZINESS/NAUSEA

Y / N BLURRED VISION

Y / N OTHER N,W,T

Y / N RECENT TRAUMA

Y / N OTHER HOSPITALISATIONS

Y / N OTHER MEDICATION

NOTES:

GOALS: