



# Welcome to aspirechiropractic.com.au

Please take a few minutes to fill out this form as completely as you can. All details given here are for use within the clinic and are confidential. If you have any questions, please do not hesitate to ask. We look forward to working with you in maintaining your health.

OFFICE USE ONLY

Patient for:

\_\_\_ Dr \_\_\_

\_\_\_ Dr \_\_\_

NAME: Miss / Ms / Mrs / Mr \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (SURNAME)

POSTAL ADDRESS: \_\_\_\_\_ Postcode: \_\_\_\_\_

HOME PHONE No: \_\_\_\_\_ MOBILE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

HAVE ANY OF YOUR FAMILY MEMBERS HAD CHIROPRACTIC CARE BEFORE:  YES  NO

DO YOU HAVE PRIVATE HEALTH THAT COVERS CHIROPRACTIC CARE:  Yes – Insurer \_\_\_\_\_  No  Not Sure

Most of our patients are referred to us by caring family or friends. How were you referred to this office?

Family/Friend Name: \_\_\_\_\_

- Google  Internet  Web Site  Signage  Yellow Pages  Yellow Pages On-Line
- White Pages  Newspaper  Mailbox Drop  True Local  Facebook  Twitter
- Shopping Centre  Other: \_\_\_\_\_

### If you have ever had Chiropractic care before, please complete the following:

NAME OF CHIROPRACTOR: \_\_\_\_\_ LOCATION: \_\_\_\_\_

WHAT WERE YOU BEING TREATED FOR? \_\_\_\_\_

No. OF TREATMENTS PROVIDED? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_ WHEN WAS YOUR LAST TREATMENT? \_\_\_\_\_

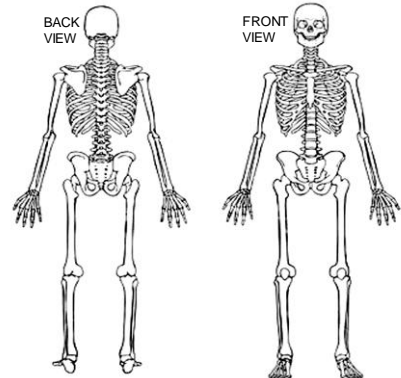
DID THE CHIROPRACTOR HAVE X-RAYS TAKEN?  Yes  No  Can't remember

### Reason for this visit:

WHAT IS YOUR REASON FOR THIS VISIT? \_\_\_\_\_

IF YOU HAVE PAIN, WHAT IS THE FREQUENCY OF PAIN: \_\_\_\_\_

DESCRIBE LOCATION OF THE PAIN or INDICATE ON THE DRAWING: \_\_\_\_\_



WOULD YOU DESCRIBE THIS PAIN AS:  Sharp  Dull  Throbbing  Aching  Burning  Other \_\_\_\_\_

ARE YOU EXPERIENCING:  Numbness  Stiffness  Swelling  Cramping  Tingling  Spasms

ARE ANY OF THE FOLLOWING DIFFICULT/PAINFUL:  Sitting  Standing  Bending  Walking  Running/Jogging  
 Lying down  Lifting  Other \_\_\_\_\_

APPROX. DATE SYMPTOMS BEGAN? \_\_\_\_\_ HAVE YOU HAD SIMILAR SYMPTOMS BEFORE  Yes  No

IS THE PAIN GETTING:  Worse  Better  Same  Comes and goes

HAVE YOU BEEN TREATED BY A HEALTH CARE PRACTITIONER FOR THIS CONDITION BEFORE TODAY?  Yes  No

IF YES WHAT TYPE:  Medical Doctor  Chiropractor  Physiotherapist  Masseuse  Other \_\_\_\_\_

**Health History:**

IN THE LAST 10 YEARS HAVE YOU HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITION:

- |  |  |  |  |                                      |
|--|--|--|--|--------------------------------------|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Wrist pain      | <input type="checkbox"/> Artificial joints/limbs | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Headache    |
| <input type="checkbox"/> Scoliosis     | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Migraine    |
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Dizziness   |
| <input type="checkbox"/> Jaw pain      | <input type="checkbox"/> Leg pain        | <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Respiratory disorders | <input type="checkbox"/> Epilepsy    |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Knee pain       | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Digestive problems    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arm pain      | <input type="checkbox"/> Ankle pain      | <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Ulcers                | _____                                |

PLEASE LIST ANY MEDICATION (INCLUDING PAIN KILLERS) YOU ARE TAKING: \_\_\_\_\_

PLEASE LIST ANY SUPPLEMENTS YOU TAKE ON A REGULAR BASIS: \_\_\_\_\_

WHEN WAS THE LAST TIME YOU DID A BOWEL OR LIVER DETOX? \_\_\_\_\_

DO YOU FIND IT DIFFICULT TO LOSE WEIGHT?:  YES  NO

DO YOU WEAR ORTHOTICS?:  YES  NO

PLEASE LIST ANY SERIOUS INJURIES OR SURGERIES YOU HAVE HAD IN THE LAST 10 (TEN) YEARS:

- Falls Date: \_\_\_\_\_ Details: \_\_\_\_\_
- Head Injuries Date: \_\_\_\_\_ Details: \_\_\_\_\_
- Broken Bones Date: \_\_\_\_\_ Details: \_\_\_\_\_
- Dislocations Date: \_\_\_\_\_ Details: \_\_\_\_\_
- Surgeries Date: \_\_\_\_\_ Details: \_\_\_\_\_
- Other Serious Injuries Date: \_\_\_\_\_ Details: \_\_\_\_\_

PERSONAL HABITS – Please circle the most relevant level in the list below:

- |                |                                 |              |                                 |
|----------------|---------------------------------|--------------|---------------------------------|
| Alcohol Intake | Heavy / Moderate / Light / None | Sugar Intake | Heavy / Moderate / Light / None |
| Coffee Intake  | Heavy / Moderate / Light / None | Exercise     | Heavy / Moderate / Light / None |
| Water Intake   | Heavy / Moderate / Light / None | Sleep        | Heavy / Moderate / Light / None |
| Smoking        | Heavy / Moderate / Light / None | Appetite     | Heavy / Moderate / Light / None |

**Women only:**

Are you pregnant?  Yes – if so how far along are you \_\_\_\_\_ months \_\_\_\_\_ weeks  No  Not sure

**Patient Information:**

**Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug free health care profession in the world.**

However, we do wish to inform you that there are some possible risks that may be associated with chiropractic care. Very rare risks may include muscle soreness, strain to a ligament or disc in the neck and lower back and aggravation of the underlying condition. Extremely rare is the risk of damage to neck blood vessels which can arise in a stroke or stroke-like symptoms. This said, **chiropractic adjustments of the spine are still internationally recognised as being far safer than medication and many other alternatives.**

If you have any questions relating to the care you are about to receive, please speak to your chiropractor.

**Informed Consent:**

*I acknowledge the above information and do not expect the chiropractor to be able to anticipate all potential risks and complications. I have also reviewed the information I have provided and believe it to be accurate. I understand that this information will be used by the clinic to help determine appropriate treatment. If there are any changes in my medical status I will inform the clinic. Based on the information provided, I consent to receiving chiropractic and or massage care in this clinic.*



\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date