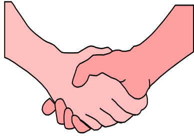
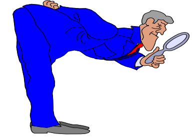


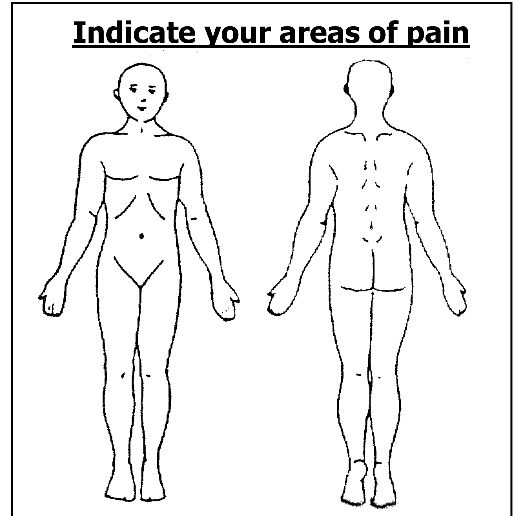
Welcome to our clinic



Please take a few minutes to complete this questionnaire so we may evaluate your condition thoroughly. When you have finished, please return it to your receptionist.

Name________________________________Date of Birth_____/_____/_______Age______(yrs)
Address______________________________Suburb___________________Postcode_________
Occupation__________________ ☎(H)______________(W)____________(M)____________
Email Address (For newsletters & Special offers)______________________________
Marital Status______________ ___Children(ages)____________Pregnant or Breast feeding? ❑yes ❑no
Do you have Chiropractic private health insurance? (claims can be electronically processed here) ❑yes ❑no
Who referred you to this clinic ? ❑Ms/Mr/Dr________________________________❑GP/Specialist
❑ Sign ❑ Website/Internet ❑ Your coach_________________________❑ Sports club/Association
Have you had previous Chiropractic care ? ❑yes ❑no Date of your last adjustment____/_____/____
Techniques your Chiropractor Used: ❑Manual adjustments ❑Massage ❑SOT ❑Activator ❑Other____

Please describe your present complaint and illustrate the affected areas on the diagram:



____
____
____

Are there any other injuries/problems bothering you ?
____
____

Please list any illnesses you have
____
____

Please list any drugs, medicines or vitamins you take
____
____

Have you had any x-rays taken in the past five years ? If yes, please detail:____

Please outline all sporting activities/training habits/hobbies and your level of participation
____
____

Please tick (✓) the corresponding box if you have suffered from any of the following:

❑ Anaemia	❑ Diabetes	❑ Thyroid disease/goiter	❑ H.I.V. / A.I.D.S.
❑ Rheumatic Fever	❑ T.B.	❑ Heart Disease	❑ Paralysis
❑ Asthma	❑ Kidney trouble	❑ High blood pressure	❑ Stroke
❑ Cancer / Tumors	❑ Epilepsy	❑ Pleurisy	❑ Ulcers
❑ Hepatitis	❑ Glaucoma	❑ Nervous breakdown	❑ Multiple sclerosis

It is customary to pay for all professional services when rendered. This centre does not send accounts. Payment for all services may be made by cash or Eftpos facility. We require a minimum of 24 hours notice for appointment rescheduling or a cancellation/non attendance fee will apply.

Client Signature________________________________Date_____/_____/_____