harwoodchiropractic
freedom to live

## PERSONAL DETAILS

| | | |
|---|---|---|
| Name: | DOB: | Sex: M / F / Other |
| What do you like to be called: | Occupation: | Phone: |
| Email: | | |
| Postal Address: | | |
| Emergency Contact: | Emergency Contact Mobile: | |

## DETAILS FOR YOUR VISIT TODAY

**What prompted this visit? (Circle all that apply - then underline the worst one)**

| | | | |
|---|---|---|---|
| Low back pain | Neck pain | Mid back pain | Headache |
| Dizziness | Hip/groin/leg pain | Shoulder/arm pain | Ear/nose/throat/sinus |
| Digestion problems | Tingling/numbness | Sleep issues | Jaw pain |
| Maintenance Care | Other: | | |

**How severe is it? No symptom 1 2 3 4 5 6 7 8 9 10 Crippling**

**Is it constant or intermittent?**

**How long has it been there?**

**What caused it?**

**Is it getting better, getting worse, or staying the same?**

**What makes it better?**

**What makes it worse?**

**Have you had this before?**

**When did you last visit a chiropractor?**

## GENERAL HISTORY

- Have you ever had a STROKE, HEART ATTACK or BLOOD CLOTS?
- List Medications you are taking: (Prescription and non-prescription)
- List any fractures, surgeries or hospitalisations? (Including non-spinal)

I consent to a chiropractic examination and if required, any imaging that the chiropractor deems necessary.

I understand that a fee for service rendered is due at the time of service and cannot be deferred to a later date.

**Signature:** _____ **Date:** _____

**Please pass on all relevant documentation to reception staff before entering the consultation room.**

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**ODI: NDI: COMI: LEFS: UEFS: DASH: SF-12:**