Name:	DOB:	Sex: M / F / Other
What do you like to be called:	Occupation:	Phone:
Email Address:		
Postal Address:		
Emergency Contact Name:	Emergency Contact Number:	
Health Fund:	How did you find out about us:	

DETAILS FOR YOUR VISIT TODAY

What prompted this visit? **Pain** **Other symptom** **Maintenance/ Health Enhancement**

If pain or other symptom:

Where is your **main** pain/symptom? **Low back** **Mid back** **Neck** **Other:**

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

Is it: **Constant** or **Intermittent**

Which best describes your pain? **Ache** **Sharp** **Burn** **Grab** **Throb** **Stiff** **Other**

Does your pain radiate to your: **Arm/s** **Leg/s** **Left / Right / Both**

Do you have: **Pins & Needles** **Numbness** **Tingling:** **If yes, where?**

How long have you had this pain/symptom?

What do you think caused this episode?

Are you: **Getting better** **Getting worse** **Staying the same**

What eases your pain?

What aggravates your pain?

Have you had this pain before?

When did you last visit a chiropractor?

GENERAL HISTORY

- Have you ever had a STROKE or HEART ATTACK?
- List Medications you are taking and why: (Prescription and non-prescription)

- List any fractures, surgeries, hospitalisations or motor vehicle accidents? (Including non-spinal)

I consent to a chiropractic examination and if required, radiographic examination, 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 imaging and relevant documentation to reception staff before entering the consultation room.