

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:	

### Your History:

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

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 X-ray and relevant documentation to reception staff before entering the consultation room.**