Ch: Type: NP Date: Scanned ☐ X-rays ☐
ROF Date: Posture ☐ Cliniko ☐

Chiro Nearby Me

PT ID

PERSONAL DETAILS:

***CONFIDENTIAL

Full Name:		**Date Of Birth:**	
Address:		**Suburb:**	
Mobile/Home #:		**Occupation:**	
Spouse / Partner Name:		**No. Children:**	
Email Address:			
Medicare Card No:		**Reference #**	**Expiry:**
Private Insurance Chiropractic Cover	**Y / N**	**WorkCover or TAC Claim No:**	
Emergency Contact:		**Emergency's Phone #**	
How did you find us? (please circle)	**Facebook Google Passing By Festival/Show GP Doctor** **Who Referred You: ……...**		

Previous Chiropractor	**Yes / No**	**Who?**	**When?**	**Did it help? Y / N**
Have you had SPINAL X-Rays ?		**YES / NO**	**If yes, when?**	
Rate your POSTURE out of 10? (10–1, Excellent - Poor)		**Height (cm):**		**Weight (kg):**

MEDICAL & GENERAL HEALTH HISTORY:

Are you PREGNANT?	
List current MEDICATIONS	
Any personal history of serious disease?	
Please list SURGERIES (incl. yr)	

STRESSES

Physical (falls, accidents, work posture) =
Bio-chemical (smoke, diet, drugs/alcohol) =
Psychological, Emotional (work, financial, relationship stresses) =

GENERAL SYSTEM REVIEW

(Tick Left box = Past symptoms, Right box = Current symptoms)

- □ □ Pins & Needles, Numbness, Weakness
- □ □ Soreness in Neck
- □ □ Dizziness/Light-headed/Vision problems
- □ □ Headaches
- □ □ Painful/Clicking Jaw
- □ □ Shoulder Pain/Stiffness/Tension
- □ □ Mid Back Pain/Tension
- □ □ Pain in Ribs or Chest
- □ □ Low Back Pain/Weakness/Stiffness
- □ □ Hip Pain/Stiffness, Buttock & Leg Pain
- □ □ Pain on Straining/Coughing/Sneezing
- □ □ Knee/Foot/Ankle trouble
- □ □ Unexplained weight loss
- □ □ Leg/Muscle Cramps
- □ □ Arm/Elbow/Wrist/Hand Pain
- □ □ Stroke (TIA)
- □ □ Loss of Smell/Taste
- □ □ Allergies, Colds & Flu
- □ □ Fatigue
- □ □ Loss of Grip
- □ □ High/Low Blood Pressure
- □ □ Smoker (___/day)
- □ □ Asthma/Coughing
- □ □ Ear Disorders
- □ □ Freq loose stools
- □ □ Cancer
- □ □ Nausea/Vomiting
- □ □ Menstrual issues
- □ □ Diarrhoea/Digestion
- □ □ Constipation
- □ □ Abdominal Pain
- □ □ Drink Alcohol(/ wk)
- □ □ Diabetes, kidney disease or heart disease
- □ □ Medical devices and implanted devices such as intra- cranial aneurysm clips, cardiac pacemaker, coronary stents, intra ocular foreign bodies and cochlear implants (circle relevant)

REASON FOR YOUR VISIT :

List COMPLAINTS	When did this BEGIN?	SEVERITY? Mild=1 Severe=10	HOW did this begin?	Have you had this BEFORE?	What makes this complaint WORSE?	What other TREATMENT have you had for this?
1.						
2.						
3.						

OFFICE USE:

NOTES

Y / N HEADACHES

Y / N DIZZINESS/NAUSEA

Y / N BLURRED VISION

Y / N OTHER N,W,T

Y / N RECENT TRAUMA

Y / N OTHER HOSPITALISATIONS

Y / N OTHER MEDICATION

NOTES:

GOALS:

`XR

Cx / Tx / Lx / Other:

2X4 1X4 , 2X6
2X6 1X6 , 1X12
OTHER:

DR - CX / TX / LX / SCOLI PP
OTHER:

REPONSE POST RX:
-Lighter Post Cx/Thx/Lx
-Tender Post Cx/Thx/Lx
-Other:

TREATMENT PERFORMED

CX:

TX:

LX:

SPINAL DECOM:

OTHER: