Chiropractor Client Registration Sheet

IMPORTANT – PRIVACY NOTICE

Information collected by us about you will be stored according to the requirements of Federal Privacy legislation. It will only be passed on where appropriate to the care of the medical problem about which you consulted us (eg to your physio or local doctor), or where legally required. If you require more information, ask a staff member to see a copy of our Privacy Policy.

Mr Mrs Miss Master Ms Dr (Please circle)

SURNAME_____ GIVEN NAME(S)_____ PREFERRED _____

DATE OF BIRTH_____/_____/_____ EMAIL ADDRESS_____

STREET ADDRESS_____

SUBURB_____ STATE_____ POSTCODE_____

TELEPHONE (H) ( )_____(W) ( )_____(Mob)_____

MEDICARE NO_____ REF No_____ EXP. DATE_____/_____ OCCUPATION:_____

REFERRAL SOURCE .(Please tick appropriate box)

❑ DOCTOR - Name_____ Address_____ REFERRAL DATE ____/____/____

❑ PHYSIOTHERAPIST - Name_____ Address_____

❑ COACH - Name_____ Sport_____

How did you hear about SSMC?

❑ PRACTITIONER REFERRAL ❑ FRIEND ❑ FAMILY ❑ WEBSITE / INTERNET

❑ OTHER (Please specify)_____

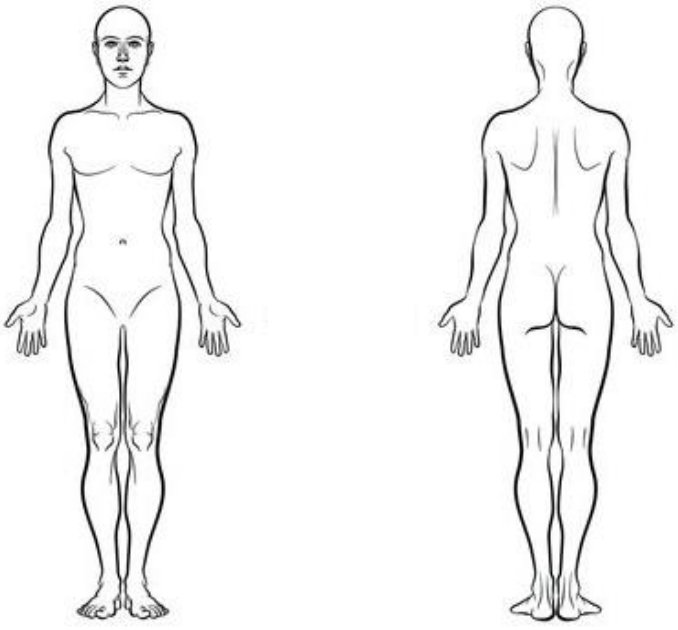
YOUR HEALTH HISTORY

Major Concern _____

Other Concern/s _____

Previous diagnosis & treatment for present condition _____

If applicable, please circle or mark with an X your main area(s) of pain on the below diagram:



List surgery, accidents, falls_____

_____

Are you on any medication? _____ Pain relief (Panadol etc)? _____

Have you had previous chiropractic care? _____ When? _____ Practitioner Name _____

Lifestyle

Skipped Meals	Coffee – Daily	Alcoholic Beverages		Do you smoke?	How happy are you with your diet?
Daily _____	☐ None	☐ None	☐ 1-2 weekly	Past / Present / Never	1 = Very unhappy
	☐ 1-2	☐ 1-2 Daily	☐ 3-4 weekly	How many daily? ____	10 = Very happy
	☐ 3-more	☐ 2-3 Daily	☐ More		_____

What sport and/or exercise do you do regularly? _____

_____ How often? _____

Please tick any conditions that you have been treated for / are currently being treated for:

Past	Present		Past	Present		Past	Present	
		Epilepsy			Shoulder Pain / Stiffness			Frequent Urination
		Dizziness			Hand Pain			Bedwetting
		Headaches			Finger Numbness / Tingling			Menstrual Difficulties
		Sinusitis			Nausea / Bloating			Low Back Pain / Stiffness
		Migraines			Heartburn / Indigestion			Hip Joint Stiffness
		Ear Disorders			Depression			Buttock Pain
		Eye Disorders			Anxiety			Leg Pain
		Jaw Pain / Clicking			Allergies			Leg Numbness / Tingling
		Mid Back Pain			Asthma			Arm Pain
		Cancer			Recurrent Sore Throat			Kidney Pain
		Neck Stiffness			Hernias			Economic Stress
		Arthritis			Constipation			Work Stress
		High Blood Pressure			Diarrhoea			Chronic Fatigue

Others: _____

Have you previously:

Been knocked unconscious	Yes / No
Fractured or broken a bone	Yes / No
Been reliant on a cane / crutch	Yes / No
Been treated for a spine / nerve disorder	Yes / No
Been hospitalised	Yes / No

When was your last:

Spinal examination	_____
Physical examination	_____
Blood / urine test	_____
Spinal x-ray	_____
Dental / chest x-ray	_____

(*IF APPLICABLE*) When did your last period start? _____ Are you pregnant? Yes / No / Unsure

FAMILY HEALTH INFORMATION

Relation	Past and / or Present Health Problems

ACKNOWLEDGEMENT

The information I have completed on this form is correct to the best of my knowledge. I have read the privacy notice overleaf. I understand that I will be personally responsible for my accounts and these are to be settled at the end of each appointment..

I agree for my details to be used anonymously for research purposes - Yes/No (Please circle) .
I agree to be contactable through any of the means listed above – Yes/No (Please circle)

PATIENT SIGNATURE_____DATE_____/_____/_____