YOUR CONFIDENTIAL HEALTH PROFILE

Davis Chiropractic

PATIENT PERSONAL INFORMATION

Given Name:_____ Surname: _____
Please circle title: Dr / Mr / Mrs / Ms / Miss / Master/ Other: _____
Preferred Name/ How would you like to be addressed by our staff: _____
Date of Birth:_____ Age: _____
Address: _____
Phone Numbers: Home: _____ Mobile: _____ Work: _____
Email Address: _____ Occupation: _____

Health Fund Name: _____Health Fund Membership #: _____ _____
Pension Concession/ Health Care Card #: _____ Expiry Date: _____
DVA #: _____ GOLD card /WHITE card (please circle)

Emergency Contact: Full Name &Title:_____
Phone #:_____Relationship to you: _____

Who referred you to our office?
☐Other Health Practitioner ☐Family ☐Friend Referrer's Name_____
☐Yellow Pages ☐Clinic Sign ☐Internet: What site?_____

Have you previously had chiropractic care? YES/NO If yes, when was your last visit? _____
Name of Chiropractor: _____ Were x-rays taken? YES/NO

PATIENT CURRENT COMPLAINT

Describe your present health complaint and how it happened:
_____
_____

How long has the problem been present _____
Is the problem getting better/worse/staying the same? (Please Circle)

Have you had any other treatment for your current complaint? YES/NO if yes, give details: _____

_____

If pain is present how would you rate you current pain level?

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Female Patients – Are you pregnant? ☐ **YES** ☐ **NO** ☐ **UNSURE**

POLICIES ON FEES, GUARANTEES AND DISCLOSED INFORMATION

1. I understand that missed appointments or appointments cancelled with less than 24 hours notice may incur a charge. This clinic does not run accounts and payment for service is required at the time of consultation.
2. I appreciate that positive results of any treatment that I receive **cannot be guaranteed**.
3. I have read and agree that all information provided is accurate to the best of my knowledge. I also agree that it is my responsibility to inform the treating chiropractor if any of the above information changes.
4. **I consent to a consultation and examination to determine if I should be under chiropractic care.**

Signature:_____ Date:_____

PATIENT REVIEW OF SYMPTOMS

Davis Chiropractic

Please tick the boxes if you have had any of the following conditions:

General
- ☐ Fever
- ☐ Sweats
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss/ gain

Head
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting episodes

Eyes
- ☐ Change in vision
- ☐ Glasses/contacts
- ☐ Cataracts
- ☐ Light Sensitivity
- ☐ Glaucoma

Ears
- ☐ Ringing in Ears
- ☐ Recurrent infections
- ☐ Hearing loss

Nose
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Allergies

Mouth
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Jaw pain
- ☐ Change in taste
- ☐ Swelling

Neck
- ☐ Lumps/ Masses
- ☐ Swelling

Lungs
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Persistent cough
- ☐ Coughing up phlegm/blood
- ☐ Tuberculosis

Physiologic
- ☐ Excessive stress
- ☐ Depression
- ☐ Anxiety
- ☐ Mood Swings

Gastro-Intestinal
- ☐ Gas
- ☐ Heartburn/indigestion
- ☐ Stomach ulcers
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Haemorrhoids
- ☐ Liver/ Gall Bladder disease

Genito-Urinary
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Increased/ Decreased urination
- ☐ Kidney stones

Vascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold/ Hot feet/hands
- ☐ Varicose veins
- ☐ Low/High blood pressure

Skin
- ☐ Rash
- ☐ Bruising
- ☐ Hair loss
- ☐ Nail changes
- ☐ Change in moles
- ☐ Itching
- ☐ Dermatitis
- ☐ Eczema

Neurologic
- ☐ Seizures/Epilepsy
- ☐ Strokes or TIA's
- ☐ Tingling
- ☐ Numbness

Muscle/bone
- ☐ Arthritis
- ☐ Fractures
- ☐ Dislocations
- ☐ Muscle strains

Conditions
- ☐ Diabetes
- ☐ Thyroid condition
- ☐ Heart condition
- ☐ Alcoholism
- ☐ Cancer_____
- ☐ Polio
- ☐ Parkinson' disease
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Anaemia
- ☐ Osteoporosis
- ☐ Other_____

Please provide information on the following (where applicable):

Medication

Prescription_____

Non-Prescription_____

Drug allergies_____

Medical

Surgery/Hospitalisation_____

Psychiatric Care_____

Substance Abuse_____

Joint Replacement_____

Family History

Cancer_____

Epilepsy_____

Heart disease_____

Diabetes_____

Social

Alcohol_____

Caffeine_____

Smoking_____

Recreational Drugs_____

Accidents/ Trauma (Include Dates)

_____

_____

_____

_____

_____