CONFIDENTIAL HEALTH QUESTIONNAIRE

Welcome to the Falcon Chiropractic Clinic. Please complete the following **updated Medical History** Form.

PERSONAL DETAILS

File No. _________

Mr/Mast/Mrs/Ms/Miss ____

Surname Given Names (in full) Preferred Name

Guardian Name if required ______________________________

Postal Address ____ Postcode __________

Email Address ____

Telephone Numbers Home _______________ Mobile ___________________Work _____________

Name of Emergency Contact ____________________________ Telephone Number _____________

HEALTH INFORMATION

What is the purpose of this visit? ____

____

What seems to make the problem better? ______________________________________

____

What seems to make the problem worse? _______________________________________

____

At what time of the day does it seem to be at its worst? __________________________

Does the pain radiate? ☐ Yes ☐ No

Do you have any other complaints? ☐ Yes ☐ No ______________________________

Please list any medications you are taking ______________________________________

____

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FALCON WA 6210
Phone: 9534 4660
Fax: 9534 4990

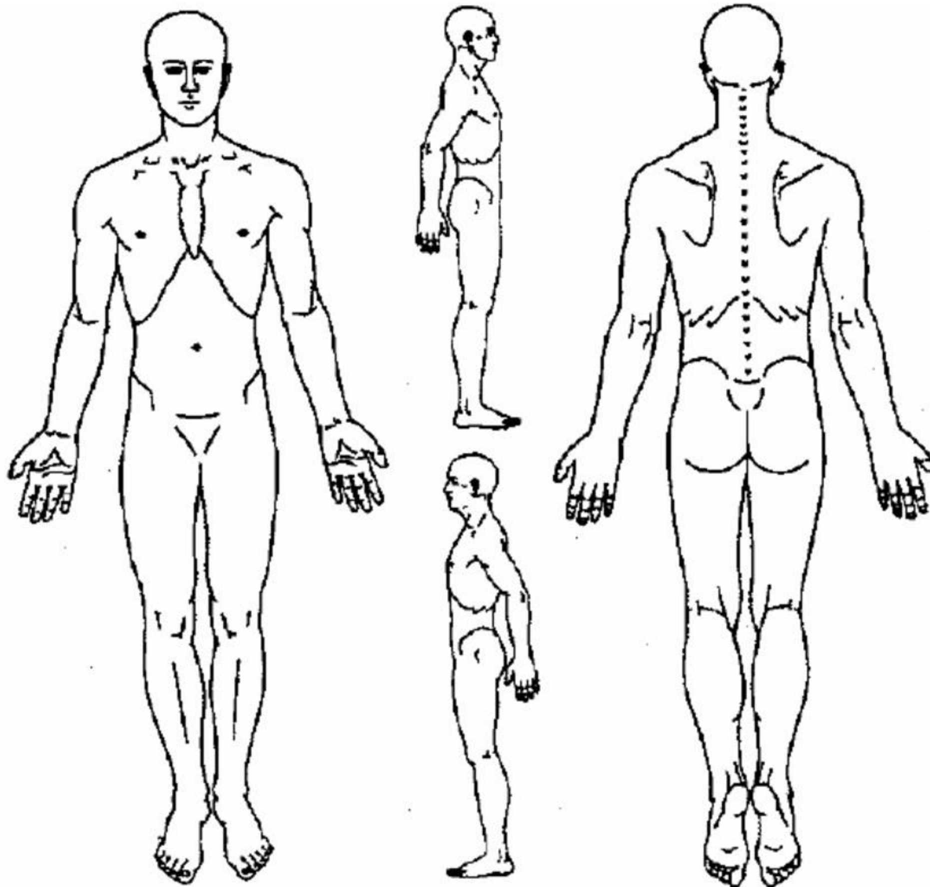
reception@falconchiropractic.com.au
www.falconchiropractic.com.au

SYMPTON DIAGRAM

Please mark the areas on your body where you feel the described sensations.

Use the appropriate symbol, include **all** affected areas

Aching	\\\\\	Numbness	**++++++**	Pins and Needles	**ooooo**
Burning	**bbbbb**	Stabbing	**sssssss**		



Using the scale provided below: rate the pain you are experiencing now

No pain **– 0** _______ **1** _______ **2** _______ **3** _______ **4** _______ **5** _______ **6** _______ **7** _______ **8** _______ **9** _______ **10 -** Unbearable

Is this a motor vehicle accident injury? ☐ Yes ☐ No

Have you lodged a claim? ☐ Yes ☐ No

If yes when was the accident date? _______________

Claim number?____________________

Is this a work related injury? ☐ Yes ☐ No

Have you lodged a claim? ☐ Yes ☐ No

If yes when was the accident date? ______________________

Claim number?____________________________

Name of Insurance Company ____

DECLARATION

I hereby declare that: 1) the information supplied is correct to the best of my knowledge: and
2) if an insurance claim is denied, then I am responsible for all fees.

Patients Signature _________________________ Patent/Guardian Signature ______________________________

Date ______________________________