FALCON CHIROPRACTIC CENTRE
health in motion

CONFIDENTIAL HEALTH QUESTIONNAIRE

Welcome to the Falcon Chiropractic Clinic. Please complete the following questionnaire. Your answers will help determine if chiropractic care can help. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate health-care provider.

PERSONAL DETAILS

File No. _____

Mr/Mast/Mrs/Ms/Miss _____
(Please Print) Surname Given Names (in full) Preferred Name

D.O.B. _____ Age _____ Guardian Name if required _____

Marital Status _____ Partners name _____ Number of children _____

Postal Address _____ Postcode _____

Email Address _____ Occupation _____

Telephone Numbers Home _____ Mobile _____ Work _____

Name of Emergency Contact _____ Telephone Number _____

Do you have private health insurance? ☐ Yes ☐ No If yes, who is your insurer _____

Are you a concession card holder? ☐ Yes ☐ No

How did you find out about us? ☐ Telephone ☐ Health Fund ☐ Sign ☐ Dr
☐ Web Page ☐ Patient/Family/Friend – Name _____

HEALTH INFORMATION

Have you had any previous chiropractic care? ☐ Yes ☐ No If so; reason _____

_____

Name of previous Chiropractor _____ Date of last visit _____

In your own words, please describe your chief complaint and when you first noticed the problem

_____

_____

What seems to make the problem better? _____

_____

What seems to make the problem worse? _____

_____

What type of pain is it? (Please check)

☐ Sharp ☐ Stabbing ☐ Achy ☐ Burning ☐ Dull ☐ Diffuse ☐ Localized

Does the pain radiate? ☐ Yes ☐ No

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

Has this problem been treated before and if yes, how? _____

_____

Do you have any other health complaints? _____

Who is your normal Medical Doctor? _____

Please list any medications you are taking _____

_____

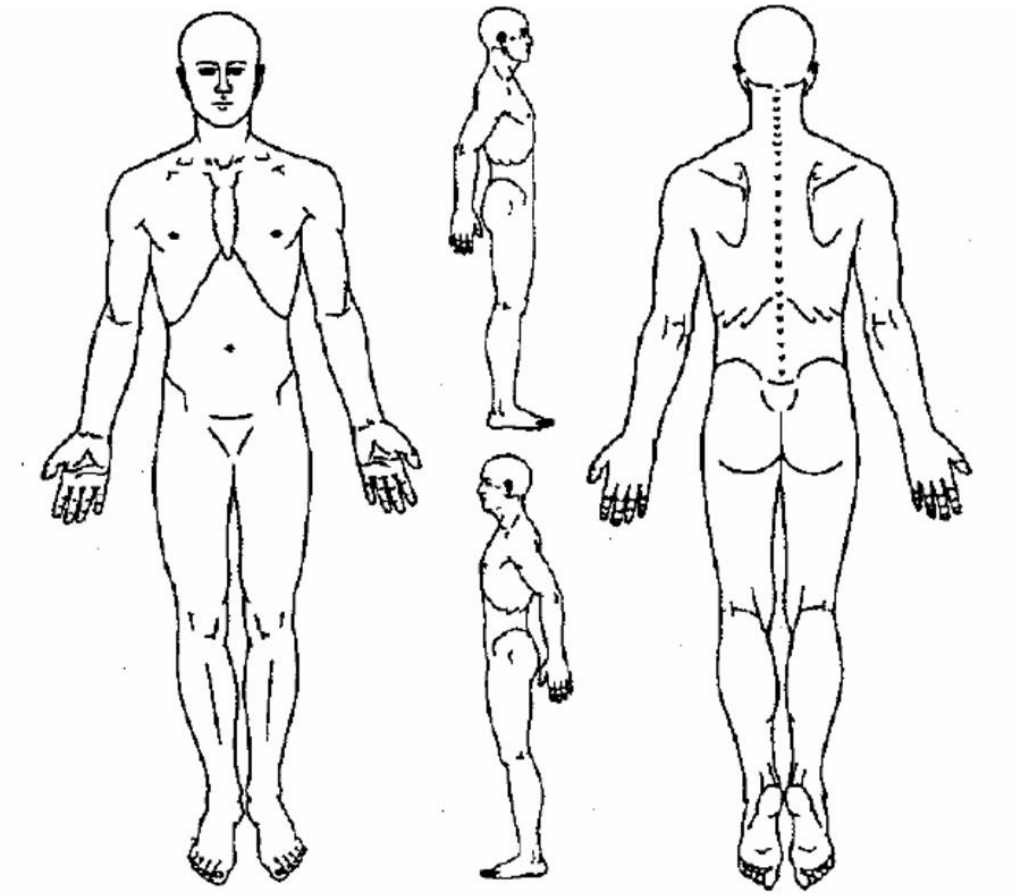
_____

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

What are your treatment goals? _____

_____

_____

Physical History

Please tick if you have had any of the following

Musculosketetal system

___ neck problems

___ upper back problems

___ shoulder problem

___ elbow/wrist problems

___ low back problems

___ knee problems
___ ankle/foot
___ arthritis
___ osteoporosis
___ concussion

Genito-Urinary system
___ painful urination
___ excessive urine
___ discoloured urine
___ gout

Nervous system
___ numbness
___ loss of feeling
___ headaches
___ dizziness
___ fainting

___ confusion
___ depression
___ forgetfulness

___ epilepsy

Gastrointestinal system
___ poor appetite
___ excessive hunger
___ abdominal pain
___ excessive thirst
___ nausea/vomiting
___ diarrhoea
___ constipation
___ liver/gallbladder trouble
___ weight loss/gain

Female
___ premenstrual syndrome
___ heavy menstrual flow
___ pregnancy

Cardio-Vascular-Respiratory
___ heart disease
___ Chest pain

___ high blood pressure

___ difficult breathing
___ persistent cough
___ coughing phlegm/blood
___ lung problems
___ varicose veins
___ diabetes
___ hypoglycaemia
___ asthma
___ stroke

Eyes, Ears, Nose and Throat
___ eye problems
___ ear ringing
___ hearing loss
___ sore throat
___ allergies
___ hoarseness

Other
___ cancer
___ psoriasis
___ any other not above

PAST HEALTH HISTORY

Previous hospitalisation or operations

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

Major falls or accidents _____ Date _____

_____ Date _____

_____ Date _____

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 _____