CONFIDENTIAL PATIENT CASE HISTORY

Lifecare CHIROPRACTIC
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Tel: (03) 9585 4044
Open until 7pm weeknights and 1pm Saturdays.
70 Balcombe Road, Mentone, 3194

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you and devise the most effective treatment plan. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

NAME_____ MOBILE PHONE _____
ADDRESS_____ HOME PHONE _____
EMAIL ADDRESS _____ WORK PHONE _____
DATE OF BIRTH_____ AGE _____ M ☐ F ☐ Marital Status _____ No. of Children _____
Your Occupation _____
Who may we thank for recommending you to our clinic? _____

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1=mild 10= worst imaginable	When did this episode start?	If you had this condition before, when?	What caused the problem?	% of time this condition affects you?
1.					
2.					
3.					
4.					

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐
How long has it been since you felt really good? _____
What have you done for this condition, was it of benefit? _____
_____
Is this condition interfering with any of the following (please tick):
Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Social/family ☐ Other

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)
_____
Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:
_____

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Have You Ever	Yes	No	Describe Briefly
Been knocked unconscious?			
Been treated for a spine or nerve disorder?			
Had a fractured bone?			
Been hospitalised?			
Been in an auto accident or major fall?			
Had any allergies?			
Have you had chiropractic care before?			

Name of practitioner _____
Date of last chiropractic care _____
Name of G.P. _____
Date of last G.P. visit _____

		Rate from 0 to 10
Are you suffering from stress?	None = 0 Extreme =10	
Do you have a healthy diet?	Terrible = 0 Excellent = 10	
How would you rate your energy level?	No Energy = 0 Full of Energy = 10	
How committed are you to achieving optimal health?	No commitment = 0 Total commitment = 10	

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each Category:

1. Physical stress (falls, accidents, work postures, etc.)

a. _____

b._____

c._____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, etc.)

a. _____

b._____

c._____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

a. _____

b._____

c._____

Family Health Information:

(Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture). Has anyone in your immediate family (including Uncles, Aunts and Grandparents) had any of the following?

☐ Heart diseases ☐ Arthritis ☐ Thyroid disease (Goitre) ☐ Diabetes ☐ Cancer

☐ Any other condition _____

Past Health History

Please mark the following conditions you may have had or have now (—have had, +have now):

Dizziness		Difficult Digestion		Headaches/Migraines		Freq./Recurrent Infections		Stroke	
Depression		Asthma		Other Mental Disorders		Constipation		Menopausal symptoms	
Neck Pain		Fatigue		Diarrhoea		High Blood Pressure		Lumps in Breast	
Pain over stomach		Nervous Breakdown		Skin Conditions		Loss of Weight		Painful Periods	
Difficulty Conceiving		Bloating/Gas		Loss of Sleep		Lower back pain		Irregular Periods	
Fainting		Ringing in Ears		Stress Related Illness		Nausea		Difficulty Carrying Pregnancy	

Other (please explain) _____

_____

Do you use birth control? If yes, how long? _____

Is there any chance you may be pregnant? Yes ☐ No ☐

Is there anything else which may help to better understand you which has not been discussed? _____

_____

_____

What outcomes would you like to achieve from attending our clinic? _____

_____

_____

Why are you here at this point in time? _____

_____

_____

IN CASE OF EMERGENCY, PERSON WE CAN CONTACT _____