Practice Name: Dynamic Chiropractic Austraila
Practice Address: 33 Murroona St. Bowen, QLD 4805 Patient Number……

DYNAMIC CHIROPRACTIC AUSTRALIA

Patient Case History

All information contained in this questionnaire is strictly confidential.

Full Name:		**Date of Birth:**
Address:		
Postal Address:		
Phone: (H)	(W)	(M)
Email Address:		**I give consent to receive communication via email.**
Occupation:		
Next of Kin Name:	**Contact Number:**	
Are you a member of a health fund that pays for Chiropractic Care? **Please ✓**	Yes	No Don't Know
If Yes, please provide name of health fund:		
Who may we thank for referring you to our Practice? Google / Other Internet Search / Yellow Pages / Newspaper / Friend or Family – Sign / Other -		

Your Health Profile

Why this form is important.

As a full spectrum Chiropractic Office, we focus on your ability to be healthy. Throughout life, events/stresses occur (physical, chemical and emotional) which damages your health expression. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, especially to your nervous system, allowing us to better access the challenges to your health potential.

If you have ever had Chiropractic Care, please complete the following:

Name of Chiropractor:			Located where?		
Why did you seek Chiropractic Care?				Date of last Adjustment:	
What were the results of your Care?	Excellent	Satisfactory	Fair	Did not help	Worsened
Did the Chiropractor take X-Rays?	Yes	No	Did you have a thorough examination?	Yes	No

Addressing the issues that bought you to this office.

Please describe the chief area/s of your complaint:

If you are experiencing Discomfort, is it? Sharp Dull Comes and goes Constant

Since the problem started, is it? About the same Getting better Getting worse

It interferes with: Work Sleep Hobbies Leisure Other

If, other please describe:

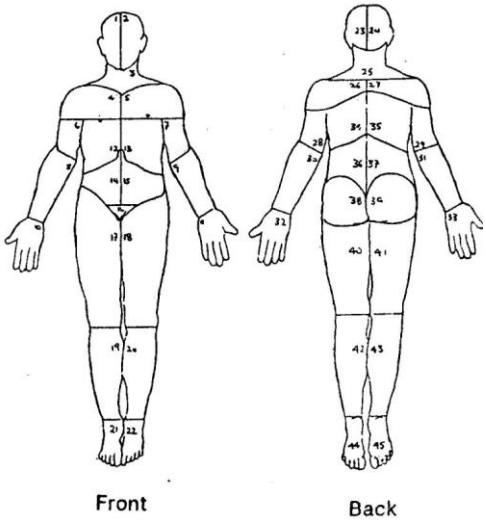
Please ✓ all symptoms you have ever had, even if they do not seem related to your current problem:

Back Discomfort	Constipation/Diarrhea	Headaches	Nausea/Vomiting	Persistent cough
Blurred vision	Depression	Indigestion	Neck stiffness	Pins and needles in arms
Bowel/bladder problems	Dizziness/Fainting	Loss of balance	Numbness in fingers	Pins and needles in legs
Chest Discomfort	Fatigue	Menstrual irregularity	Numbness in toes	

Currently your symptoms are aggravated by:

Bending	Reaching	Straining at stool
Coughing	Sitting	Walking
Lifting	Sneezing	Other
Neck movement	Standing	

Please circle affected areas



The Beginning Years (to age 17)					
Did you have a difficult birth process?	Yes	No	Unsure		
Did you participate in aggressive youth sports?	Yes	No	Unsure		
Did you have any childhood illnesses?	Yes	No	Unsure		
Was there any prolonged use of medication such as antibiotics or an inhaler?	Yes	No	Unsure		
As a child, were you under regular Chiropractic Care?	Yes	No	Unsure		
Did you have any serious falls/injuries as a child?	Yes	No	Unsure	If Yes, What and When:	
Did you have any surgery?	Yes	No	Unsure	If Yes, What and When:	

Adult (18 years to present)						
Have you had any serious health problems?	Yes	No	unsure			
Have you been in any motor vehicle, motor bike accidents or major falls?	Yes	No	Unsure	If Yes, What and When:		
Have you had any surgery or been in hospital?	Yes	No	Unsure	If Yes, What and When:		
Have you fractured or broken any bones?	Yes	No	Unsure	If Yes, What and When:		
On a scale of 1 – 10, describe your stress levels (1 = zero 10 = Extreme)	Occupational:			Personal:		
On a scale of Poor Good Excellent describe your:	Diet:		Exercise:	Sleep:	General Health:	

	Never	Occasionally	Moderately	Excessive	
Alcohol					
Smoking					
Coffee					
Sodas					

Are you currently taking any of the following?

Anti-inflammatory Muscles relaxants Medication for any discomfort Anti-depressants HRT Vitamins
Birth Control Other. Please list:

Medical Doctor's Name:

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

Family Health Profile	
At our office we are not only interested in your health and well-being, but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:	
Mother:	Father:
Spouse:	Children:
Others:	

Lifestyle Profile
What do you want to gain from Chiropractic Care?
What are your ultimate health goals/desired outcome?
What is your passion in life? Hobbies/Special interests.

For Women	
Are you pregnant? Yes No Unsure	Date of last menstrual cycle:
Please ✓ if you have the following: Tender breasts Lumps in breast Period Discomfort Irregular periods	
Hot flushes Discomfort during intercourse Bleeding between periods Excessive menstrual flow Vaginal discharge	

PLEASE READ AND SIGN	
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to take postural photos and 'specific postural x-rays' if required.	
Patient's/Guardian's Signature:	**Date:**