CONFIDENTIAL PATIENT INFORMATION

Welcome to Bundilla Family Chiropractic … our mission is to help you and your family to get healthy and stay healthy for a lifetime,
so to enable us to best assist you with your health and lifestyle goals, please complete the following questionnaire..

Personal Information

Full name:	**Date:**
Address: Street City State postcode	
Home phone: ( )	**Work phone: ( )**
Mobile phone:	**Email address:**
Marital status: M S W D	**Spouse/guardian name:**
Date of birth:	**No. of children:**
Occupation:	**Spouse's Occupation:**
Pregnant? Yes ☐ No ☐	
Health Fund Company	**Does it cover Chiropractic care? Yes ☐ No ☐**
Name of person responsible for your fees:	

Who may we thank for referring you? ______________________________

What is the major Heath Concerns that Brought You Into This Office?

*If you have no symptoms or complaints and are here for Chiropractic Wellness Care, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity (eg Low Back Pain)	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

____

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

What have you done for this condition? Was it of benefit?

____

I do (do not) have a family history of this or similar symptoms (Please explain):

____

Which activities aggravate your condition? ____

Other practitioners you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
" Wellness care?" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Physiotherapist	☐
Other (please describe)	☐

Medical doctors Name:	Date of Last visit
What was the purpose of visit?	
Did it help?	What did they do?

Have you had to make changes in your life due to this pain, illness, condition, etc? Y / N
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

The accumulation of stresses on our body over time establishes our level of health and this influences the severity of our symptoms and our ability to heal. Please pay close attention to this as it will help us to help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	
2. Type:	When?	
3. Type:	When?	
4. Type:	When?	

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

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

Current Medicines and Supplements

Please list any medications/drugs or nutritional supplements you have taken in the past 6 months and why: (prescription and non-prescription)and why.

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Question	Response
Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would you help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Do you suffer from food allergies or is there a particular type of diet that you usually follow?

____

Past Health History

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

☐ Epilepsy	☐ Sore Throats	☐ Hand Pains	☐ Blood Pressure	☐ Low back pain/ stiffness	☐ Hip Joint stiffness
☐ Dizziness	☐ Thyroid Problems	☐ Finger Numbness	☐Emphysema	☐ Kidney pain	☐ Buttock Pain
☐ Headaches	☐ Stiff Neck	☐ Heartburn/ indigestion	☐ Gall Bladder Problems	☐ Frequent Urination	☐ Testicular Pain
☐ Sinusitis	☐ Arthritis	☐ Asthma	☐ Diarrhea	☐ Bed Wetting	☐ Depression
☐ Migraines	☐ Cancer	☐ Allergies	☐ Constipation	☐ Menstrual Difficulties	☐ Sexual Disorders
☐ Ear Disorders	☐Shoulder Pain/ Stiffness	☐ Mid-back Pain	☐ Ulcers	☐ Nervousness	☐ Leg pain
☐ Jaw Pain	☐ Arm Pain	☐ Heart Disease	☐ Hernias	☐ Prostate Trouble	☐ Leg Numbness

Stressors

Because accumulation of stress affects our health and ability to heal and may be the cause of our health condition, please list any obvious stresses (you have ever had) in each category:

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

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

   ____

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

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

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

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Important Information About This Practice And Your Privacy

From 21 December 2001, new privacy laws came into effect in Australia that regulate the way the Practice handles your personal information. These laws give you new rights, such as the right to access personal information held about you and the right to correct it if needed. The new laws also state how the Practice may collect, disclose, store and keep safe your personal information.

To enable the Practice to continue to deliver and enhance the products and services it provides, the Practice holds personal information about you. We recognize and support your right to privacy in relation to this information and will continue to handle it with care and in accordance with our professional and legal requirements.

The Practice staff will continue to demonstrate integrity and understanding by keeping secure your personal information.

We ask you to read the Practice's **"Privacy Statement".** We invite you to contact our Privacy Officer if you would like to discuss this matter further.

If you wish to know more about our information handling practices you may ask us about our **"Privacy Policy".**

I understand that this clinic does not hold accounts and that all fees are payable at the time of service and cannot be deferred to a later date.

I have read the section regarding my personal information and understand this Practice's position on patient privacy.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.
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Print Patient Name: ______________________________ Date: ________________

Signature: ______________________________

(0r Parent/ Guardian signature if under 18)

Name of Parent/ guardian: ____