Mooroolbark Chiropractic CENTRE

Name: _____ Mr/Mrs/Miss/Ms/ Mstr/Dr/Prof
Age: _____ Date of Birth: _____ Male ☐ Female ☐
Address: _____
_____
Home:_____ Mob:_____ Work:_____
Email _____

Medicare Number _____
Medicare Ref No (the number next to your name) _____ Expiry_____
Do you have Private Health Insurance Y/N
If yes, Name of fund _____
Is your chiropractic care covered by Veteran Affairs, Y/N
Work Cover or a 3rd party? If yes, please present your referral form to us.

Occupation or if retired/unemployed, your previous occupation: _____
Next of kin's full name: _____
Relationship to you: _____ Their contact number: _____
Do you have any children? Y/N Child/ren's names & ages: _____
_____

GP's Name _____
Clinic Name _____
Address _____
Phone No. _____
Do you give us permission to contact your GP to inform Y/N
them that you have started receiving Chiropractic Care? Signature:_____

How did you find out about our clinic?
☐ Family/Friend Name: _____Did you receive a voucher from them? Y/N
☐ Another Health Professional Name: _____
☐ Google search ☐ Yahoo engine search
☐ Facebook ☐ Our Signage
☐ Yellow Pages Web ☐ Yellow Pages Book
☐ Posture check/talk ☐ Previous patient of Dr Pauline Walsh
☐ Other advertising _____

Have you received chiropractic care before? ☐ No ☐ Yes
If yes, when was your last visit _____
Were you pleased with the service provided and why? _____

The Chiropractor is expertly trained and efficient in traditional manual and light force instrument adjustments. Which do you prefer?

□ Traditional Manual □ Instrument Adjustment □ Unsure, would like to discuss

Have you ever had any spinal X-rays taken? □ No □ Yes

If yes, what date_____, and which spinal areas;

□ neck □ mid-back □low-back □pelvis.

YOUR HEALTH OBJECTIVES

People consult this office with one or more of the following health objectives please indicate which apply to you:

□ For relief of my symptoms only.

□ For correction of the underlying causes of my symptoms and health problems.

□ To prevent the development of symptoms, health problems and degeneration.

□ To achieve an optimal level of health and well-being.

PRESENT STATE OF HEALTH

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major problem area _____

Pain/problem started on _____triggered by_____

Have you had previous episodes of this problem?_____

Pain is: □ Sharp □ Dull □ Constant □ Intermittent

Is the pain referring to any other areas of your body?_____

Is the condition getting worse? _____

What aggravates, brings on your condition or makes it worse? _____

What relieves your condition or makes it feel better? _____

Is this symptom/condition interfering with?

□ Work □ Sleep □ Routine □ Other _____

Other doctors/practitioners seen for this condition _____

Any home remedies used? _____

Please list any drug both prescriptive and non-prescriptive and any Vitamin/Mineral supplements you currently or recently have used:

Drug/Medication Name	Dosage	Reasons for use

□ I understand that payment is required at the time of consultation (unless paid online)

□ I understand that I am required to give 12 hours' notice if I need to reschedule an appointment, otherwise there is a $40 missed appointment fee

□ I understand that the 'Facebook offer' does not include treatment

Patients Signature _____

Date: _____