

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 Mooroolbark Chiropractic Centre requires payment at the time of consultation and that I am required to give 12 hours notice if I need to reschedule an appointment, otherwise there is a \$40 missed appointment fee.

Patients Signature _____

Date: _____