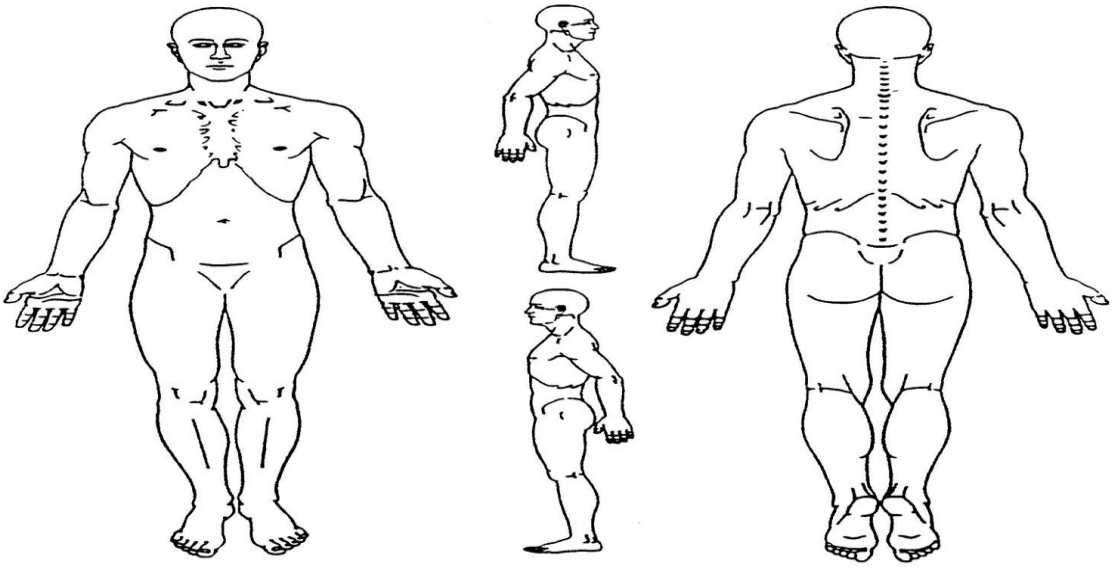
Macarthur Natural Health Clinic

Confidential Client History

Dr / Mr / Mrs / Miss / Ms Surname _____ First Name _____
D.O.B_____ Male / Female Occupation_____
Address_____Post Code_____
Phone (H) _____ (W)_____ (MOB)_____
Email Address_____
Family Doctor_____
How did you find out about us?_____
If referred by a friend let us know so we can thank them_____
Major Complaint_____
Date of onset of this complaint_____Have you seen a chiropractor before? Yes/No
Have you had any other treatment for your current problem? YES/NO if yes, what treatment?_____
Do you have any allergies to oil or latex? Or any_____
Please indicate any are of **pain, pins & needles, numbness, weakness or other symptom**



Please indicate the severity of the pain NOW

0_____**10**
No pain **Worst pain you have ever had**

PRECONSULTATION HEALTH QUESTIONAIRE

What relieves your symptoms?_____
What makes symptoms worse?_____
Are your symptoms worse at night or at any specific time of the day? _____

Please circle the following YES/NO questions where applicable: Have you experienced / suffered...

YES / NO A change of weight of more than three kilos in the last year?
If YES, was it unexplained weight loss_____
YES / NO Back ache?
If YES, is this ever accompanied by pain down one or both legs_____
YES / NO Neck Pain?
YES / NO Any numbness or tingling in your arms, hands, legs or feet?
YES / NO Often troubled by headaches?
If YES, do they make you nauseous / sick?_____
YES / NO Pain and aching in your stomach?
If YES, is it relieved by eating / drinking milk?_____
YES / NO Does the pain often wake you at night?
YES / NO Any persistent change in your appetite during the last 3 months?
YES / NO Frequent loose bowel movements?
YES / NO Constipation?
YES / NO Blood or mucus in your movements / stools?
YES / NO Shortness of breath / tightness in the chest on exertion?
YES / NO Cramp like pain in either leg when walking?
YES / NO Blackouts, dizzy spells or faints?
YES / NO Frequent or persistent cough?
YES / NO Change in frequency of passing urine?
YES / NO Any lumps, cysts or swellings anywhere on your body?
YES / NO Depression, anxiety or stress?
YES / NO Did you / do you smoke?
YES / NO Did you / do you take recreational drugs?
YES / NO Do you exercise regularly?
YES / NO Do you get cold hands or feet?
YES / NO Do you have varicose veins?

Are you currently taking any form of medication? **YES / NO** If yes list them all:_____
_____
_____

Please go to the next page

PRECONSULTATION HEALTH QUESTIONAIRE

WOMEN'S QUESTIONAIRE

Are your periods: regular / slight irregular / very irregular

Please circle:

Have they ceased?	**YES / NO**
Are you taking a contraceptive pill / have an IUD fitted?	**YES / NO**
Are you periods accompanied by lower abdominal pain or discomfort?	**YES / NO**
Do you notice bleeding between period times?	**YES / NO**
Have you had any children?_____ Ages:_____	
Have you had any gynaecological or abdominal operations?	**YES / NO**
Does coughing, straining or laughing make you pass water?	**YES / NO**
Have you had a lump in either breast?	**YES / NO**

Do you have or have you ever had a serious health problem such as hypertension, heart disease, diabetes or any form or cancer? YES / NO

_____

_____

Have you had any broken bones? YES / NO if yes, which ones and how?_____

_____

Please read

Our practice specialises in treating problems of the spine and associated disorders of the nervous system. A Large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please circle and complete the following:

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

_____

(Signature)

_____

(Print Name)

_____

(Date)