THE BACK CLINIC
Optimal Spine equals Optimal Health

***What is the reason for your consultation today?***

- o ***Quick Fix: Symptoms Relief***
- o ***Find Cause: Correction***
- o ***Maximise Health Potential***

***The Spine should be properly Checked and Maintained throughout life, When was your Last Chiropractic Adjustment***_____ When were your last **Chiropractic X-rays** taken ?_____

Surname: _____ First Name:_____ Mr/Mrs/Ms/Miss_____

Address: _____ Postcode:_____

Home Phone: _____ Work Phone:_____ Mobile Phone:_____

Email Address: _____

Are you currently pregnant? _____

Date of Birth: _____ Age:_____ Sex: o Male o Female

Occupation: _____ Hours Per Week:_____ Employer:_____

Partner's Name: _____ Partners Occupation:_____

Children's Names & Ages: _____

Private Health Fund? o Yes o No Which One? _____ Chiropractic Cover? o Yes o No

Medicare Number _____Expiry Date_____ Number on card_____

Who may we thank for referring you/how did you find our office? _____

***"Most people, including children have experienced many things that could cause spinal misalignments or 'Subluxation', Which affects your nervous system and your whole health."***

Are you consulting our office for a o **Wellness Evaluation** OR o **Specific Health concern**

Please describe your spine/health problems below:

1. _____ for how long?_____
2. _____ for how long?_____

What do you think caused this problem(s)? _____

Other Doctors you have seen for this problem(s)? _____

**Please tick any of the following symptoms you have experienced at any time in the past 12 months:**

| | | |
|---|---|---|
| o Headaches/Migraine | o Pain between shoulders | o Lower Back Pain |
| o Dizziness/ Ringing In The Ears | o Asthma/Breathing Problems | o Leg pain/Cramps |
| o Numbness/Tingling In Arms/ Hands | o Chest Pain | o Numbness/Tingling In Legs/ Feet |
| o Neck pain/Stiffness | o Reflux | o Hip Pain |
| o Difficulty Sleeping | o Digestive System Problems/ IBS | o Constipation/Diarrhoea |
| o Allergies/Sinus | o Weight Problems | o Bowel/Bladder Problems |
| o Nervousness/Depression | o Fatigue/Energy Levels | o Infertility |
| o Recurrent Flu/Colds | | o Menstrual Problems |

Have you ever been diagnosed with the following? (Please circle) If **YES** please indicate WHEN.

Cancer Heart Disease Diabetes Stroke Other

**List** any organs removed & surgeries you have had?

_____

_____

**List** any medications that you are currently taking

_____