Patient Information Questionnaire

PERSONAL DETAILS

Mr/Mrs/Miss/Ms FIRST NAME_____

SURNAME_____

SPOUSE or GUARDIAN'S NAME_____

ADDRESS_____SUBURB_____P/C_____

PHONE (H)_____ (W)_____ (M)_____

EMAIL_____

DATE OF BIRTH_____/_____/_____ AGE_____ OCCUPATION_____

G.P.'S NAME_____ADDRESS_____

PREVIOUS CHIROPRACTOR/S_____

HOW DID YOU FIND US: Family/Friend/G.P./Sporting Club/Yellow Pages_____

WHAT IS YOUR MAIN REASON FOR SEEKING CHIROPRACTIC_____

_____

Do you know what caused your condition?_____

Are there any activities/position which aggravate your symptoms?_____

Does anything help your pain or mobility?_____

Have you had the problem before? Y / N If so, on how many occasions_____

Are you aware of any incidents/circumstances that may have contributed to the onset of your symptoms?_____

_____

Have you consulted any other health professional? If so, please provide details_____

_____

ACCOUNT DETAILS

Payment of your account in full is expected at the time of each visit.

Private Health Insurance_____ Membership No._____ ID Number on Card _____

(Please come prepared to pay your account in full if the health fund is down or your benefit limit has been reached)

Centrelink Issued Health Care Card Y / N Pension Card Y / N Student Card Y / N

Veteran Affairs_____ Card ID. No._____

Is your condition the result of a motor vehicle accident in which you were not at fault, or a work injury? Y / N

If so, please advise your claim number, and the name of the company to whom accounts should be sent

_____

MEDICAL DETAILS

Have you ever been hospitalized? Y / N If so what for?_____

Have you had any operations? Y / N If so what for?_____

HAVE YOU EVER HAD:

High Blood Pressure	TB	Rheumatic fever	Psoriasis	Meningitis	Encephalitis
Diabetes	Cancer	Hepatitis A/B/C/D	Aneurysm	Malaria	Osteoporosis
Asthma					

Please turn over

HAVE YOU HAD ANY RECENT:

Nausea	Palpitations	Blurred vision	Cold hands or feet
Shortness of breath	Reduced energy	Bruise or bleed easily	Night Sweats
Weight loss or gain	Difficulty swallowing	Changes in sensation	Dizziness
Chest pain	Fever	Change of bladder or bowel function	

Have you noticed any unusual symptoms?_____

Do you take any regular medications: _____

Are you currently taking Cortisone Y / N Anti inflammatory Y / N Warfarin Y / N

Do you smoke Y / N If so, how often? _____

Do you drink alcohol Y / N If so, how often? _____

HAVE YOU EVER SUSTAINED ANY PHYSICAL TRAUMAS?

Falls Car accidents Broken bones Sporting injuries Assaults Other_____

Details_____

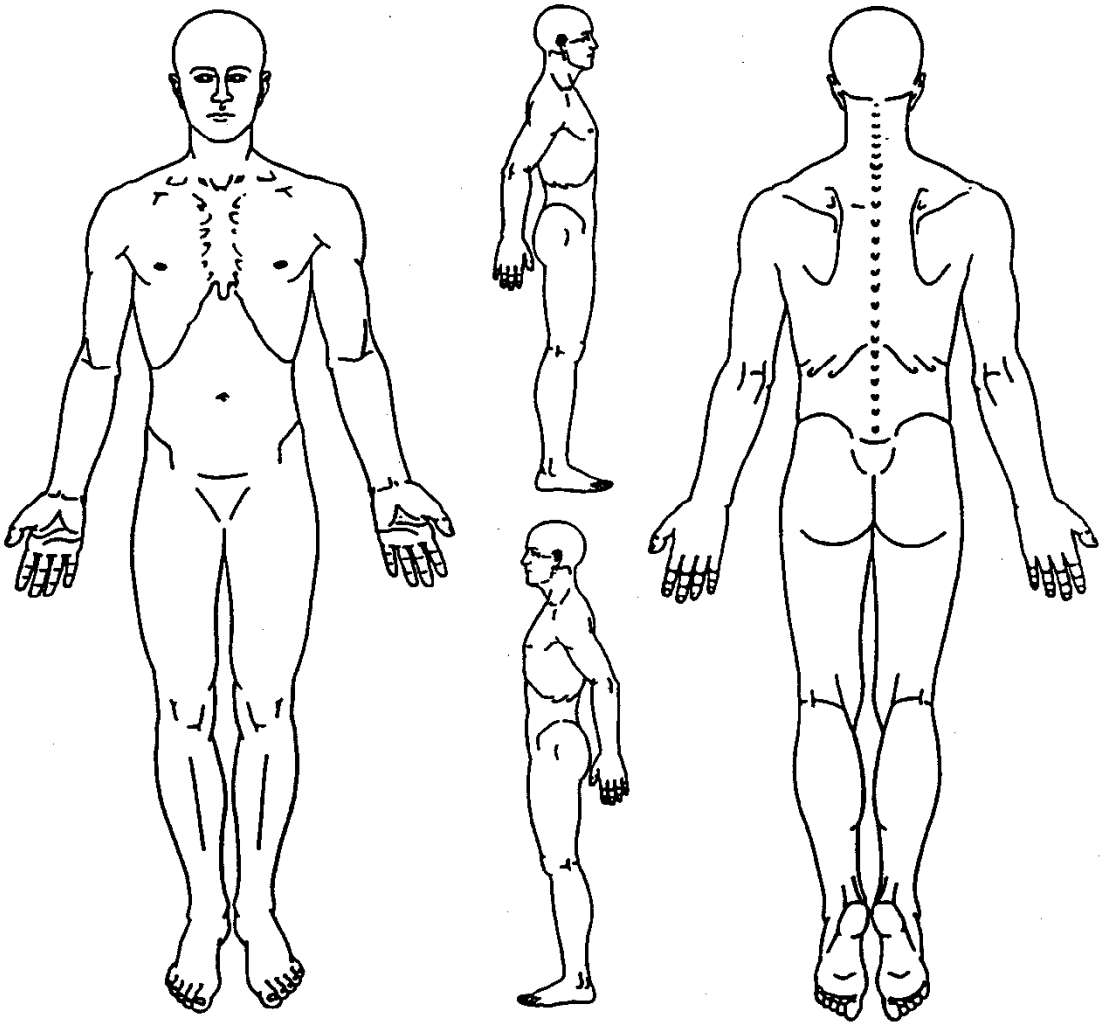
_____

ANY OTHER COMMENTS_____

_____

PLEASE USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS NOW

A – Ache	**B** – Burning	**N** – Numbness
P – Pins and Needles	**S** – Stabbing	**O** - Other



Please turn over

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CONSENT TO COLLECT INFORMATION

I _____, acknowledge that Chiroactive ('the clinic") will collect and retain personal information about me in order to keep full records. I understand that these records are kept for the purpose of assisting with the provision of effective and appropriate care both now and in the future, and for general administrative purposes.

I consent to this information being obtained, recorded and held by the clinic.

I understand the clinic undertakes to treat all information provided in accordance with the Federal Privacy Act 2001 and I have been given the opportunity to examine the clinic's privacy policy.

I understand that I may amend my details at any time, and that I have a right to access the information collected about me.

I do/do not give my consent for the clinic to contact me regarding goods, services, and/or promotional offers.

I do/do not wish to ever be sent clinic newsletters or other communications.

Name:_____

Signature:_____

Date: / /

Please ask if you have any further questions regarding this matter.