Patient information form (please PRINT)

Name:			D.O.B	
Address		Suburb	postcode_	Δ
Phone numbers: home	work _		mobile	
Email	Occup	oation	Employer	
Regular Medical Doctor or Clini	c			
Emergency Contact:	Number		Relationship to	you
Partner/ Spouse:		no of Children	_ Do they attend this c	linic? Y/N
Who is responsible for your acco	ount? Yourself/Wo	orkcover/Comcare	/TAC/Veterans Affairs	(circle)
Do you hold a Concession Card? Y	/N Type_			
Private Health Insurance Y/N				
What is the reason/s that you have				
Do you have any other health co				
Sport/exercise and how often? _				
How did you find out about Bett	er Backs?			
Any medications (include contracep	otive medications)_			
Any vitamin or herbal Supplements	s?			
Coffee(cups per day) Tea (cu	aps per day) W	ater (glasses per da	y)	
Cigarettes (per day) Alcoh	nol (how often and l	now much?)		
Have you ever seen a chiropractor b	pefore? YES/NO (c	ircle) if yes who, wh	nen and what for?	
Have you or a family member ev	ver been diagnosed	d with the followir	ng?	
Cancer Y/N Stroke Y/N	Autoimmune disord	ers (ie, SLE, RA) Y	//N Diabetes Y/N	
Osteoporosis Y/N Heart attac	k or other heart con	ditions Y/N B1	ood disorders Y/N	
Mental health disorders Y/N Other	her (specify)			

Have	you ev	er been	hospita	ılized or	had ar	ny <u>surge</u>	<u>ry</u> ? Y/N	l specif	y if yes			/	X
In the	e last 12	2 month	s have y	you had	the Flu	ı or any	other in	nfection	/s?				
1. On	a scale	1 to 10 h	ow would	d you rate	e your p	ain right	now						
No Pai	in 1	2	3	T 4	5	6	Unb	earable Pa	ain 9	10	\neg		
							,						
2. Ple No Pai		rk your le	ast pain	(L), aver	age paiı	n(A) and		ain(W) in earable Pa		<u>ek:</u>			
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¹ Halderman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: The Chiropractic experience. CMAJ 2001;165:905-906.
² Carey PF. A report on the occurrence of cerebrovascular accidents in chiropractic practice. J Can Chiropr Assoc

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