LIGHT CHIROPRACTIC AND WELLNESS Shop 1/198-206 St Johns Road Glebe NSW 2037 t 02 9660 5055 f 02 9660 7677

Personal History

Name ..... Today's Date .....

Date of Birth ..... Relationship status ..... Partner's Name .....

Children (ages) ..... Occupation .....

Address .....

Suburb ..... State ..... Postcode .....

Home ..... Work ..... Mobile .....

Email .....

**** Please Select:*** ☐ I'd love to receive quarterly newsletters! ☐ Please only use my email for personal correspondence.

Who referred you to this office? .....

What has brought you to this office and how do you hope to benefit from the care given here?
(Please tick all that apply)

- ☐ Symptom relief
- ☐ Less tension/increased flexibility
- ☐ Better posture
- ☐ Personal growth
- ☐ Improved health and wellbeing
- ☐ Improved ability to cope with stress
- ☐ Greater energy levels
- ☐ Continuing care

Please describe .....

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Have you had previous Chiropractic care?

☐ No ☐ Yes - When was your last adjustment? .....

To help us understand you better, please answer the following questions as completely as you can.

Do you have any problems with the following:

- ☐ Headaches
- ☐ Dizziness
- ☐ Vertigo
- ☐ Blurred Vision
- ☐ Ears Ringing
- ☐ Night Pain
- ☐ Stroke
- ☐ Arthritis
- ☐ Diabetes
- ☐ Serious Illness
- ☐ Cancer
- ☐ Heart Attack
- ☐ Bronchitis
- ☐ Asthma
- ☐ Allergies
- ☐ Osteoporosis
- ☐ Nausea
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Incontinence
- ☐ Urinary Tract Infection
- ☐ Menstrual Problems

Please describe .....

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Do you have any physical, emotional or mental symptoms other than those you've just listed? .....

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Please list all major physical traumas that you have experienced (falls, motor vehicle accidents, broken bones, etc.):

Past Year .....
Past 5 Years .....

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5+ years (include date) .....

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Please list any major surgery, including major dental or orthodontal work:

Past Year .....
Past 5 Years .....
5+ years (include date) .....

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Please describe any significant emotional stresses experienced:

Past Year .....
Past 5 Years .....
5+ years (include date) .....

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Are you pregnant? (How many months?) .....

Have you had a baby recently? (Date) .....

Do you make any repetitive movements or hold any prolonged postures during the course of your day? (at work, at home, in sports & hobbies, etc.)

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Please list any current medications and your reasons for taking them:

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Important Information

Any practitioner who uses manipulation is required to inform patients of possible adverse reaction. Over the years there have been rare incidents of stroke or stroke-like symptoms (usually temporary), which have occurred after neck manipulation. The chance of this happening is 1 in 5.85 million (Neck manipulations Haldeman, et al. Spine vol. 24-8 1999). There is more chance of being hit by lightening than having such a reaction. No one in Australia has died from neck manipulation. There are other small risks, which include muscle and joint strains and sprains, where full recovery follows. Numerous physical tests with or without x-rays help to minimise the risk of any adverse reactions to your treatment. If you have any further questions, please do not hesitate to ask.

Patient Signature _____ **Date** _____