WELCOME TO OUR PRACTICE

|  |  |
| --- | --- |
| DATE | Click here to enter a date. |

**PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| TITLE | Mr Mrs Miss Ms Other (please specify): | | |
| FIRST NAME/S |  | SURNAME |  |
| DATE OF BIRTH | Click here to enter a date. | OCCUPATION |  |
| STREET ADDRESS |  | | |
| SUBURB |  | POSTCODE |  |

**CONTACT DETAILS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MOBILE |  | | HOME |  | | | WORK | |  |
| EMAIL |  | | | | | | | | |
| How were you referred to Kingsford Chiro Clinic? | | | | |  | | | | |
| Emergency Contact Name | |  | | | | Relationship | |  | |
| Emergency Contact Number | |  | | | |  | |  | |

Please rate your pain/discomfort level

*(Please select)*

-None-

1

2

3

4

5

6

7

8

9

10

-Severe-

**HEALTH DETAILS**

Please mark the area of injury or discomfort on the diagrams below



|  |  |
| --- | --- |
| Major Complaint |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is this a Workers Compensation claim? | | Yes No | | |
| PRIVATE HEALTH FUND IN USE | |  | | |
| FAMILY DOCTOR |  | | LAST VISIT DATE |  |

Please mark any of the following medical tests which have been performed in the **last 3 months**:

Note: click on the tickbox to mark it

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Blood Test |  | Bone Density (Osteoperosis) |  | Prostate Exam |
|  | Blood Pressure |  | Breast Exam |  | X – Ray |

|  |  |
| --- | --- |
| Do you have any illnesses? If so, please specify |  |

Please mark the tickbox if you have any conditions involving the following systems:

Note: click on the tickbox to mark it

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Ears |  | Eyes |  | Nose |
|  | Cardiovascular (Heart) |  | Digestive (Stomach) |  | Bowel |
|  | Skin |  | Vascular (Blood/Vessels) |  | Genitals |
|  | Psychological |  | Throat |  | Respiratory (lungs) |
|  | Endocrine (Hormones) |  | Bladder |  |  |