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 |  |  |