Coast Chiropractic
CABOOLTURE

14 Annie Street, Caboolture Qld 4510
Ph: 07 5495 8455
Fx: 07 5495 8404
Em: admin@coastchiropracticcaboolture.com

New Patient Case History

Name: Date:

Address: City: Postcode:

Home Ph: Work Phone: Mobile:

Date of Birth: Age: Gender: Height: Weight:

Email Address:

Marital Status: Spouse/Partner Name:

Number of Children: Children's Names & Ages:

Occupation: If retired or unemployed, your previous occupation:

Name of your Health Fund:

How were you referred to our clinic:

PRESENT STATE OF HEALTH

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major complaint: _____

For how long? _____ triggered by: _____

Have you had previous episodes of this problem? ☐ No ☐ Yes - Number of times: _____

Previous diagnosis/treatment for this complaint: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Continuous ☐ Better

Is the pain referring to other areas of your body? ☐ No ☐ Yes - Where? _____

Is the condition getting worse? ☐ No ☐ Yes

What aggravates/brings on your condition or makes it worse? _____

What lessens/relieves your condition or makes it feel better? _____

Is this symptom/condition interfering with: ☐ Work ☐ Sleep ☐ Routine

☐ Other (please specify) _____

Is there any pain if you cough, sneeze, bowel motion: ☐ No ☐ Yes

Have you seen other Doctors/Practitioners for this condition? ☐ No ☐ Yes

If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other

Please list any home remedies employed: _____

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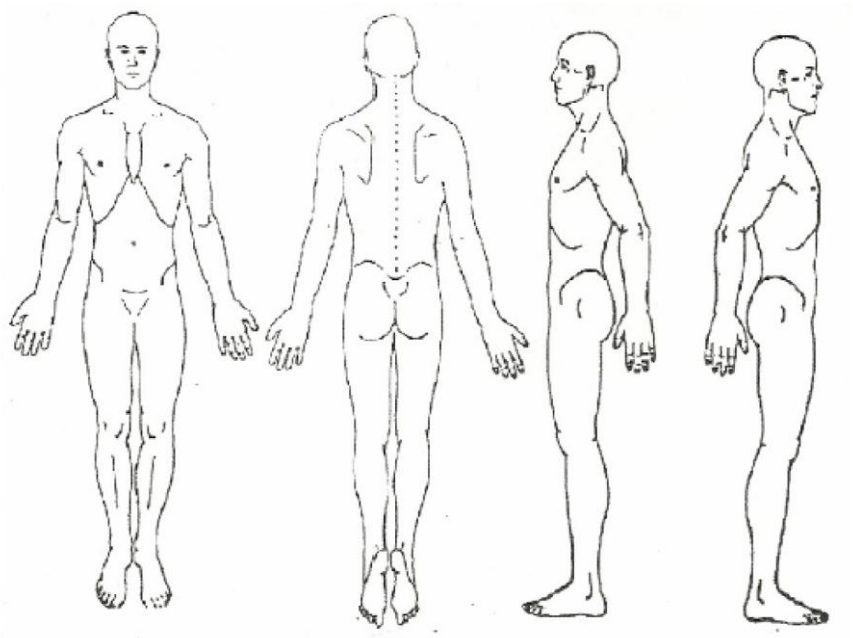
PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE:



Other complaints: _____

_____

_____

Previous diagnosis / treatment for this complaint:		
List any surgeries:		
List any fractures:		
List any accidents or falls:		
Have you had Chiropractic care:	When:	For how long:
Date of last Chiropractic adjustment:	Have you ever had Chiropractic x-rays	When:
Name of Chiropractic Doctor:	City/State:	
Name of Medical Doctor	City/State:	

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FAMILY HEALTH HISTORY

Many health problems are the result of hereditary spinal weaknesses. Information about your family's health history will give us a better picture of your total health. List any members of your family who have had any health problems such as migraines, strokes, heart disease, blood diseases, arthritis, spina bifida etc.

Relationship to You	Past or Present Health Problems

PSYCHOSOCIAL

Have any of the following occurred recently?

☐ Depression	☐ Divorce	☐ Drugs/Alcohol Increase	☐ Anxiety
☐ Death (Family or Friends)	☐ Change in job status	☐ Sleep disturbances	☐ Family problems

CONDITIONS

Have you been treated for any of the following:

☐ Alcoholism	☐ Emphysema	☐ Diabetes	☐ Multiple Sclerosis
☐ Thyroid	☐ Scarlet Fever	☐ Rheumatic Fever	☐ Cancer
☐ Tuberculosis	☐ Cold Sores	☐ Anaemia	☐ Epilepsy
☐ Diphtheria	☐ Pneumonia	☐ Mumps	☐ Stroke
☐ Ulcers	☐ Venereal Disease	☐ Heart Disease	☐ Aterioscierosis
☐ Asthma	☐ Appendicitis	☐ Glandular Fever	☐ Eczema
☐ Allergies	☐ Measles	☐ High Blood Pressure	☐ Polio
☐ Attention Deficit Disorder	☐ Arthritis	☐ Migraines	
☐ Infertility			

FOR FEMALES ONLY

When did your last period start?

_____

Are you pregnant?	☐ Yes	☐ No
Do you experience painful menses?	☐ Yes	☐ No
Is your menses irregular?	☐ Yes	☐ No

Are you trying to:	☐ Gain weight	☐ Lose weight	☐ Neither
Do you exercise?	☐ Daily to weekly	☐ Occasionally	☐ Never
List type of exercise / sport:	_____		
Do you sleep well?	☐ No	☐ Yes	
Do you smoke cigarettes?	☐ No	☐ Yes	
How many daily?	☐ 0	☐ 1 – 3	☐ 4 +
How long have you smoked?	_____		

If you used to smoke, when did you stop? _____

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NUTRITION/OTHER

Number of meals skipped	_____ Daily		_____ Weekly	
Personal satisfaction with diet	☐ Not satisfied		☐ Satisfied	☐ Very Satisfied
Cups of coffee daily	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 4+
Cups of tea daily	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 4+

Alcoholic beverages consumed

Daily	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 4+
Weekly	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 4+

With regard to any medication you currently or have recently used, please list:

Drug/medication Names (if known)	Reasons for use

YOUR HEALTH OBJECTIVES

Pain Relief	(Patch-up or symptom care only)	☐
Pain Relief and Rehabilitation	(Patch-up and Restore)	☐
Preventable Health Care	(Better long term health outcomes)	☐

_____ _____

Patients Signature Today's Date