DATE ___/____/____

TITLE _____

SURNAME _____ GIVEN NAMES _____

ADDRESS _____

SUBURB_____ POSTCODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE _____

EMAIL _____

DATE OF BIRTH _____ OCCUPATION _____

PRIVATE HEALTH COVER – NO ◯ YES ◯ HEALTH FUND NAME _____

EMERGENCY CONTACT NAME & PHONE NUMBER _____

HOW DID YOU HEAR ABOUT US ?

◯ WEBSITE ◯ DIRECTORIES ◯ SIGNAGE ◯ OTHER (please specify) _____

◯ REFERRED BY ANOTHER CLIENT - NAME _____

◯ PROMOTION / EXPO (please specify) _____

◯ Would you like to receive an SMS for future appointments ? (Chiro/Massage appointments)

◯ Would you like a family member or friend to receive a $10 gift voucher? If YES, please provide email address
(For New Chiro and Massage Clients Only)

NAME _____

EMAIL _____

NAME _____ DATE OF BIRTH _____

What is the purpose of your visit? _____

Have you had any other healthcare in the last 12 months? ◯ YES ◯ NO

If yes, please describe:

_____

Please list all medication, nutritional supplements and herbal medicines you are currently taking:

_____

List all major traumas and operations that you have undergone: _____

_____

Have you or a family member had any of the following illnesses?

◯ Cancer ◯ hepatitis ◯ allergies ◯ diabetes

◯ asthma ◯ thyroid disease ◯ heart disease ◯ seizures

Have any of the following occurred recently?

◯ Depression ◯ Chronic fatigue ◯ Increased work stress ◯ Change in job status

◯ Change in job status ◯ Economic Stress ◯ Sleep disturbances ◯ Death of someone close

◯ Drug/alcohol increase ◯ Divorce ◯ Anxiety ◯ Family problems

◯ Other: _____

(Females only) – is there a possibility you may be pregnant? YES / NO

NUTRITIONAL STATUS

Meals skipped (weekly):	◯ none	◯ 1-3	◯ 4-7	◯ 8 or more
Coffee consumption (daily):	◯ none	◯ 1-2	◯ 3-4	◯ 5 or more
Alcohol Consumption (weekly):	◯ none	◯ 1-4	◯ 5-9	◯ 10 or more

	Past	Now		Past	Now		Past	Now
Head Discomfort			Knee Discomfort			Chronic Cough		
Neck Discomfort			Feet Discomfort			Digestive Malfunction		
Shoulder Discomfort			Eye Discomfort			Nausea/Vomiting		
Arm Discomfort			Loss of Taste/Smell			Allergies		
Torso/abdominal Discomfort			Nervousness			Constipation/Diarrhoea		
Rib Discomfort			Insomnia/Sleeping			Haemorrhoids		
Upper back Discomfort			Dizziness			Urinary Discomfort		
Mid Back Discomfort			Sinus Discomfort			Menstrual Discomfort		
Lower Back Discomfort			Ear Discomfort			Loss of Libido		
Hip Discomfort			Hay Fever			Sexual Discomfort		
Buttock Discomfort			Recurrent Sore Throat			Irritability (Chronic)		
Leg Discomfort			Asthma			Fatigue (Chronic)		