First Foremost Chiropractic

Office Only
Date:
File #:

Initial consultation form

Name: _____ DOB: _____
Home Address: _____ Phone (H): _____
Phone (W): _____ Occupation: _____
Marital Status: _____ Email: _____

Next of Kin Details (contact in case of Emergency)
Name: _____Relationship:_____
Contact Number:_____

1. Please describe your present problem:

_____

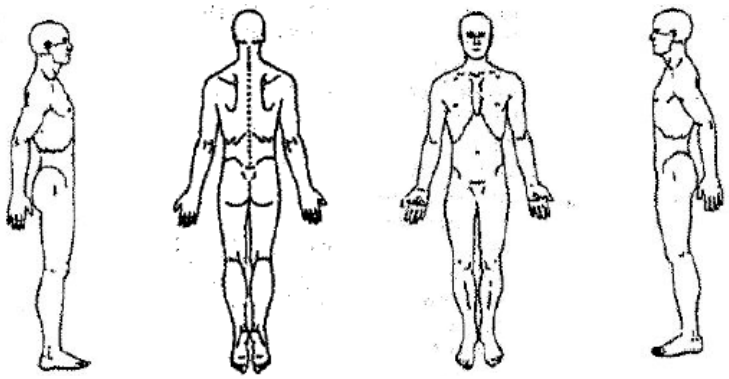
When did this problem start? _____Have you had the problem before (or similar)?_____
What were you doing? _____
What makes it worse? _____
What makes it better? _____

2. Describe the feelings you have with this problem (Please circle)

Health problems: (eg headache, bowel changes)	None	Yes	Specify:	
Pain:	Sharp	Dull	Throbbing	Numbness
Referral:	Numbness	Tingling	Burning	Where: _____
How frequent is it? (Circle):	Constant	Intermittent	Activity Dependant	
How much irritation does it cause:	None	Mild	Severe	

How would you describe the intensity now?0__ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 (worst pain ever)

3. Please mark on these pictures where you have pain or other symptoms.



Are your symptoms (Circle): Increasing Decreasing Not changing
Are your symptoms worse (Circle): In the morning / Afternoon / Increases through the day / Same all day
Have you been treated for this problem before? _____ Who by: _____
Have you had a similar problem before? _____ How was it cared for? _____
Are you taking any medications / supplements? _____

Family History

Has any of your immediate family had any of the following conditions? (if yes, indicate who eg. Mother)

Cancer _____ Blood pressure _____ Diabetes _____ Stroke_____

Heart Trouble _____ Migraine _____ Other _____

Systems Review

Do you have now, or have you ever had, any of the following (Please tick):

General / Constitutional
__Unexplained weight loss
__Excessive fatigue
__Prolonged fever / chills
__Other

Head / Eyes / Ears / Nose / Throat
__Frequent or severe headaches
__Wear glasses or contact lenses
__Chronic nasal discharge/sneezing
__Impaired hearing
__When was your last eye exam?
__Other

Cardiovascular
__Any heart trouble
__Pain or pressure in chest / Angina
__Rheumatic fever
__Palpitation or pounding heart
__Swelling of ankles
__High blood pressure
__Other

Respiratory
__Chronic cough
__Asthma or wheezing
__Shortness of breath
__Shortness of breath at night
__Other

Haematological / Lymph
__Anaemia
__Excessive bleeding / bruising
__A transfusion
__Any swelling of lymph glands
__Other

Gastrointestinal
__Abdominal pain
__Loss of appetite
__Change of bowel habits
__Blood in stool
__Haemorrhoids or rectal disease
__Other

Genitourinary
__Frequent urination at night
__Frequent or painful urination
__Difficulty holding urine
__Difficulty stopping / starting urine flow
__Urinary tract infection
__Other

Musculoskeletal
__Pain in joints / arthritis
__Other Chronic back pain or injury
__Other

Endocrine
__Cold or heat intolerance
__Excessive thirst or hunger
__Other

Skin / Breast
__Change or new growth in mole
__Breast lump
__Breast nipple discharge
__Other

Female
__Mid-cycle bleeding
__Vaginal discharge
__Painful periods
__Are your periods regular
__Problems with sexual function
__Pain with intercourse
__Have you ever been pregnant
__Other

Male
__Sore or discharge from penis
__Lump or pain on testicle
__Problems with sexual function
__Other

Emotional
__Do you have trouble sleeping
__Are you often depressed
__Are you often anxious or nervous
__Ever had had loss of memory

Neurological
__Memory loss
__Fainting, dizziness, convulsions
__Other

What is your stress level like (1 minimal, 10 major / burnout) in:

Work _____ Home Life _____ Financial _____ Health _____ Other _____

Do you smoke? _____ How Much? _____ Do you drink alcohol? _____ How much per week? _____

Who is your regular GP? _____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION INCLUDING SENSITIVE AND HEALTH INFORMATION

Information is collected from you in a lawful manner fairly and without undue intrusion. First & Foremost Chiropractic Pty Ltd uses this information only for the purposes for which it was collected or a related purpose. I understand that the details of my case may be used as teaching aids, in examinations or for research purposes. I agree to this. I understand that the use of these details will in no way divulge my identity.

Patient's Name _____ Date:_____

Patient's Signature _____(or Guardian if patient is a minor)