Welcome to **SYNON** chiropractic

Personal Information

Name: _____ Date: _____

Address:_____ Postcode: _____

Phone: (Hm): _____ (Wk): _____ (Mob): _____

Best time/place to contact you: _____

Age: _____ D.O.B._____ Email:_____

Marital Status: M S W Div Partner's Name: _____

Your Occupation: _____ Partner's Occupation: _____

Type of work: sitting _____ computer _____ standing _____ driver _____ lifting _____ other _____

Names of Family Members & ages: _____

Health Fund: _____ Workcover: _____ TAC: _____

Who may we thank for referring you to our office? _____

Addressing What Brought You Into This Office

*If you have no symptoms or complaints and are here for Chiropractic Wellness Care, please skip to the **"General Health History"**.*

Health Concerns

Please list your current health concerns according to their severity.	Rate of Severity 1 = mild 10 = worst	When did this start?	Have you had this problem before? When?	% of time pain is present.
1.				
2.				
3.				
4.				

Is your pain □ dull □ sharp Does it radiate anywhere? If so, where ? _____

_____

Since your pain started is it about the same □ getting better □ getting worse

What activities aggravate your condition? _____

_____

What have you done for this condition? Was it of benefit? _____

_____

Is this condition interfering with any of the following:

□ Work □ Sleep □ Daily routine □ Sport/exercise □ Other (please explain)

_____

Have you ever had x-rays of your spine taken? □ Yes □ No Do you still have them? □ Yes □ No

Do you wear orthotics or heel lifts? □ Yes □ No

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	□
"Wellness" Chiropractor (focuses on health and wellbeing as well as the underlying cause of pain and health concerns)	□
Medical Doctor	□
Other (please explain)	□

General Health History

Often times, accumulation of life's stresses can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any falls, injuries, accidents: car, work related or other? (especially those related to your present problems).

1.Type:	When?	Hospitalized? ☐ Yes ☐ No ☐
2.Type:	When?	Hospitalized? ☐ Yes ☐ No ☐

Have you had any surgery? (please include all surgery)

1. Type:	When?
2. Type:	When?
3. Type:	When?

Current Medications

Please list any prescription medications you are currently taking and why:

_____

Please list any over the counter medications you are currently taking and why:

_____

Past Health History

Please tick the following conditions you have suffered from, especially in the last 12 months:

☐ Allergy	☐ Constipation	☐ Heartburn	☐ Pins & needles, arms / legs
☐ Arthritis	☐ Depression	☐ Heart disease	☐ Pneumonia
☐ Asthma	☐ Diabetes	☐ High blood pressure	☐ Prostate problems
☐ Alcoholism	☐ Diarrhea	☐ Light headedness	☐ Ringing in the ears
☐ Anemia	☐ Dizziness	☐ Loss of balance	☐ Sciatic pain
☐ Arteriosclerosis	☐ Eczema	☐ Low back pain	☐ Sinus problems
☐ Back pain	☐ Emphysema	☐ Menstrual problems	☐ Stomach ulcers
☐ Blurry Vision	☐ Gall Bladder Problems	☐ Migraine headaches	☐ Stroke
☐ Cancer	☐ Gout	☐ Neck pain	☐ Tension / irritability
☐ Chest pain	☐ Headaches	☐ Nervousness	☐ Ulcers

Other (please explain) _____

_____

_____

I consent to a professional and complete chiropractic examination and to any x-ray examination that the doctor deems necessary.

Print Patient Name: _____ Date: _____

Signature: _____