



Life Chiropractic & Wellness

Adult Health Questionnaire

Name: Title:_____ First name:_____ Surname:_____

Gender: M / F Date of birth:_____

Address:_____ Suburb:_____ Postcode:_____

Contact numbers: H:_____ W:_____ M:_____

Email:_____ Occupation:_____

Private health fund:_____ Children: _____

Have you been to a chiropractor before? Yes/No. Name:_____ When:_____

How did you hear about us? Signage Internet Facebook Website

Family/Friend: Name:_____ Other:_____

Current health

Major symptom/concern:_____

How long have you suffered this complaint?:_____ Triggered by?_____

Describe pain: Sharp Dull Burning Constant Intermittent

Are the symptoms: Getting worse Staying the same Getting better Comes and goes

What brings on the problem or make it worse:_____

What relieves the problem or makes it better:_____

Have you seen anyone else about this problem? Yes/ No GP Chiro Physio

Other Details:_____

Do you have or have you had any of these symptoms/problems in the past?

Neck pain/stiffness Difficulty sleeping Poor posture

Muscle tone Depression/Anxiety Coordination/balance

Headaches/Migraines Bowel/Bladder problems Dizziness/tinnitus

Digestion issues Hip/Knee/Leg/Foot Asthma

Constipation/diarrhoea High/low blood pressure Chest pain

Incontinence Heart disease Stroke/Stroke like symptom

Numbness/tingling Jaw pain Memory/concentration

Diabetes Reflux/ indigestion Menstrual problems

- | | | |
|---------------------------------------|--|---|
| Low Back <input type="checkbox"/> | Recurrent colds/flu's <input type="checkbox"/> | Visual disorder <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Seizures/convulsions <input type="checkbox"/> | Sinus problems <input type="checkbox"/> |
| Joint pain <input type="checkbox"/> | Fatigue <input type="checkbox"/> | Scoliosis <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Grinding/clenching <input type="checkbox"/> | Cancer <input type="checkbox"/> |
| Osteoporosis <input type="checkbox"/> | Thyroid problems <input type="checkbox"/> | Ear/Eye problems <input type="checkbox"/> |

Do you take any medications?: _____

Do you have any medical conditions? Details: _____

Have you had any major accidents/ trauma/falls? Details: _____

Have you had any surgeries or been hospitalised? Details: _____

Do you have any other problems/concerns: _____

Do you smoke? Yes/ No If yes, how many per day? _____

Do you drink alcohol? Yes/ No If yes, how many per week? _____

Do you take recreational drugs? Yes/No Details: _____

How do you rate your diet? Poor Good Very good Excellent

How stressful is your life? Low Moderate High Very High

Is there family history of? Cancer Hearth disease Stroke Diabetes

Is there anything else you want us to know: _____

Cancellation and fee policy

All fees is to be paid on the day of consultation. For your convenience we have hicaps and eftpos facilities available for you to be able to claim your private health fund rebate on the spot.

Life Chiropractic and wellness has a 24-hr cancellation policy. We require a minimum notice of 24 hours to cancel or reschedule appointments to avoid a \$30 cancellation fee. This includes any missed appointments.

I, _____ acknowledge the a above cancellation policy and give Life Chiropractic and wellness permission to charge me a cancellation or missed appointment fee as appropriate.

Signed: _____ Date: _____