CHIROPRACTIC CLINIC
CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your chiropractor needs to know of any problems which may affect treatment.

PLEASE PRINT LEGIBLY

NAME ______ SEX: M/F ______

DATE OF BIRTH ______ OCCUPATION ______

ADDRESS ______ POST CODE ______

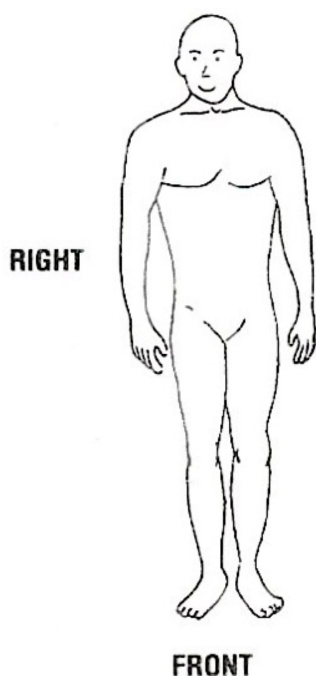
TEL NO: HOME ______ WORK ______

YOUR DOCTOR'S NAME ______

ADDRESS ______ POST CODE ______

HOW DID YOU FIND OUT ABOUT US? ______

RIGHT



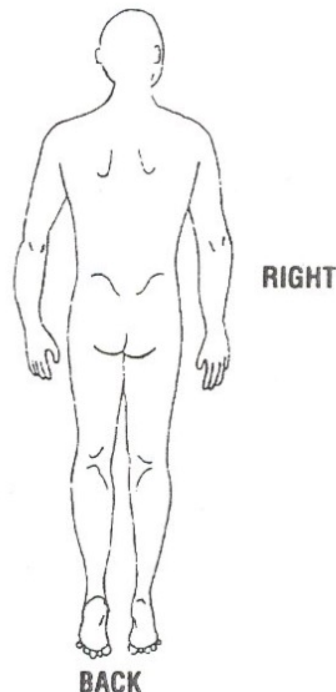
LEFT

FRONT

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol.
Include all affected areas.

Numbness	= =	= =
Burning	XXX	XXX
Pins and Needles	000	000
Stabbing/Sharp pain	///	///
Aching/Tension	●●●	●●●

LEFT



RIGHT

BACK

YOUR COMPLAINT:	YES	NO	DETAILS
1. Is this condition constant?			
2. Did it occur suddenly?			
3. Have you had it before?			
4. Is it relieved by rest?			
5. Are you able to cope with your normal activities?			
6. Please underline if it is AGGRAVATED by: COUGHING, SNEEZING, SITTING, STANDING, WALKING, BENDING, GETTING UP FROM SITTING, GETTING OUT OF BED, CAR			
7. Please underline if it is RELIEVED by: BED REST, SITTING, STANDING, WALKING, STRETCHING, PAIN PILLS, BENDING			

ARE YOU:	YES	NO	DETAILS
1. Please underline if attending or receiving treatment from a GP, physiotherapist, osteopath or consultant?			
2. Taking any medicines from your doctor? (Tablets, creams, ointments)			

HAVE YOU:	YES	NO	DETAILS
1. Had jaundice, liver, kidney, stomach or intestinal disease problems?			
2. Ever been told you have a heart murmur or heart problem, angina, high cholesterol, abnormal blood pressure, heart attack? (give details)			
3. Ever been tested positive for HIV, Hepatitis B or any other infectious diseases? Give details.			
4. Been involved in a car accident, had serious falls, sport injuries or other injuries? Give details.			
5. Ever broken any bones?			
6. Had any previous surgery?			
7. Been hospitalised? If "YES" what for and when?			

DO YOU:	YES	NO	DETAILS
1. Have arthritis?			
2. Have a pacemaker, or have you had any form of heart surgery?			
3. Suffer from allergies eg hayfever, eczema etc? Give details			
4. Suffer from bronchitis, asthma or any other chest conditions?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes?			
7. Bruise easily following falls or injury?			
8. Are there any other aspects concerning your health that you might think the chiropractor should know about?			

Many health problems are the result of hereditary spinal weaknesses, hence, information about your family members will give a better understanding of your total health picture. Please tick appropriate box(es).

RELATION	NAME	PAST AND PRESENT HEALTH PROBLEMS				
		Back Pain	Neck Pain	Headaches	Leg/Arm Pain	Other Health Problems
Father						
Mother						
Brother						
Sister						
Children						

FOR FEMALE PATIENTS ONLY	YES	NO	DETAILS
1. Is there any possibility of you being pregnant?			
2. Date of last menstruation			
3. I confirm that I am not pregnant	Signed		Date

PRIVATE HEALTH INSURANCE

Are you claiming benefits because of an accident at work or insurance claim for a motor vehicle accident? ☐

Are you covered by private health insurance? If so which one?________________________ ☐

Due to an accident or other reasons do you require a full chiropractor legal report for solicitor/insurance purposes ☐

Completed by: Self / Patient / Guardian Signature: ....

Date: ....