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161 Burns Bay Road  
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Chiropractic  
Central

Suite 9, 1 Rialto Quay Drive  
Hope Island Resort  
Hope Island, QLD 4212  
T: +61 (0) 7 5530 8494  
F: +61 (0) 7 5530 8365

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## Chiropractic Registration and History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medicare Card Number: \_\_\_\_\_ Ref No: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Email: \_\_\_\_\_

Names & Ages Of Any Children: \_\_\_\_\_

*Whom may we thank for referring you?* \_\_\_\_\_

### Patient Condition

*Please Tick if you are here for wellness care*

Reason for visit: \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

Is your condition getting progressively worse? \_\_\_\_\_

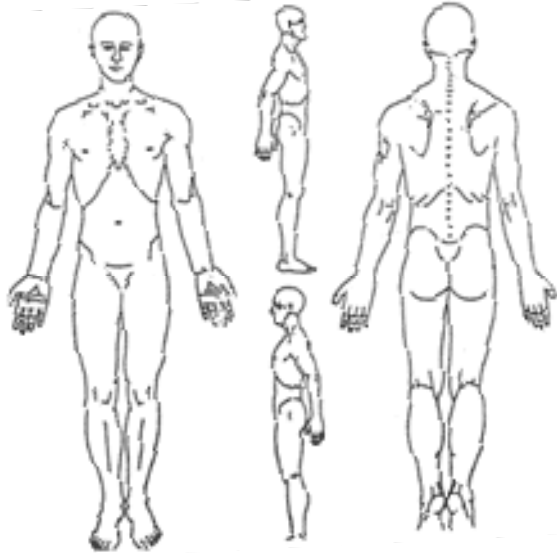
Rate the severity of your condition (0 least – 10 severe) \_\_\_\_\_

Type of Pain: **Please Circle** *Sharp Dull Throbbing Burning Numbness Cramping Other* \_\_\_\_\_

Frequency of Pain: Constant? \_\_\_\_\_ Irregular (come & go)? \_\_\_\_\_

Does it interfere with: **Please Circle** Work Sleep Daily Routine Recreation

Activities that are most painful?



Please put an X on the picture where you have pain, numbness or tingling

## Health History

Have you received other types of care for your condition? Chiropractic  Massage   
Medication  Surgery  Other

Please name other Doctors that have cared for you?

Date of last Spinal Examination? (X-Ray, MRI, CT or Bone Scan)

Please **circle** any current conditions you may have and **tick** any conditions you have had in the past.

HIV/AIDS	Alcoholism	Allergies	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Belching	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataract
Colds	Chicken Pox	Depression	Diabetes	Dizziness
Emphysema	Epilepsy	Hearing Loss	Heart Disease	Fatigue
Fractures	Glaucoma	Goiter	Gonorrhea	Gout
High Cholesterol	Hepatitis	Hernia	Herniated Disc	Herpes
High Blood Pressure	Insomnia	Miscarriage	Kidney Disease	Liver Disease
Loose Bowels	Measles	Headaches	Pacemaker	Hot flushes
MS	Mumps	Osteoporosis	Prostate Cancer	Parkinson's
Period Pain	Pinched Nerve	Pneumonia	Polio	Poor Circulation
Prosthesis	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Scarlet Fever
Sinus Problem	Stroke	Stomach Pain	Suicide Attempt	Swollen Joints
STD's	Thrush	Thyroid Problems	Tonsillitis	Tumors/Growth
Typhoid Fever	Ulcers	Vision Problems	Vaginal Infections	Whooping Cough
Wind	Colds/Flu	Viral Infections	Fibromyalgia	
Migraines	PMS	Other		

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***For women only:*** Are you Pregnant? Yes/ No/ Not Sure Due Date

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Date of last menstrual Period?

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List any Childbirth complications and/or interventions:

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*Please circle , answer Y or N or fill in blanks*

### Exercise

None  
Moderate  
Daily  
Extreme Sports  
Weight Lifting

### Work Activity

Sitting \_\_\_\_\_ Hrs per day  
Standing \_\_\_\_\_ Hrs per day  
Lt Labour \_\_\_\_\_ Hrs per day  
Heavy Labour \_\_\_\_\_ Hrs per day  
Other

### Habits

Smoking \_\_\_ Cigs per day  
Alcohol \_\_\_ drinks per day/week  
Coffee/Caffeine \_\_\_\_\_  
High Stress Level \_\_\_ Reason?

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### Injuries/Surgeries

Descriptions

Date

Falls:

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Head Injuries/Whiplash:

---

Broken Bones/Dislocations:

---

Surgeries:

---

Cancer:

---

### Medications/Vitamins/Herbs/Minerals

Please list any of the following you are currently taking.

Medications:

---

Vitamins:

---

Supplements:

---

# Trauma History Form

Please list any vehicle accidents:

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Please list any sports/recreational activities you currently do:

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Please list any past sports/recreational activities:

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Please list any slips, strains, twists or falls you may have had:

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Are there any other accidents/injuries you may not have mentioned yet?

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Are there any other kinds of stress: Mental, Physical, Chemical or Spiritual that you may not have mentioned?

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What are your ultimate goals for visiting Chiropractic Central?

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I hereby authorize the Doctor to perform any necessary diagnostic procedures, including X-ray to fully evaluate my condition for the presence of vertebral subluxation.

**Patient Signature:**

**Date:**

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