Southside Chiropractic & Massage

Unit 4/232 South Road Morphett Vale SA 5162. Ph 8382 2255

Chiropractic / Sports Injuries New Patient Questionnaire.

Welcome to Southside Chiropractic and Massage! Please assist us by filling in the following questionnaire.

Name ..... Mr. Miss Mrs. Ms. Mast. Dr.
FIRST MIDDLE SURNAME

Address .....
STREET NAME & No. / PO BOX SUBURB / TOWN POSTCODE

Phone Numbers ....
MOBILE WORK HOME

Email Address..... Date of birth ..... / ..... / .....

Occupation .....Employer .....

Number of Children ..... Marital Status ..... Name of Spouse or Next of Kin .....

Who recommended us to you?..... Name of your GP .....

Do you have private health insurance covering chiropractic, and if so, which company?.....

What is the major health issue which prompted your visit today?

.....

When did you first notice your main condition? .....

What caused it?.....

Is it getting any better or worse? .....

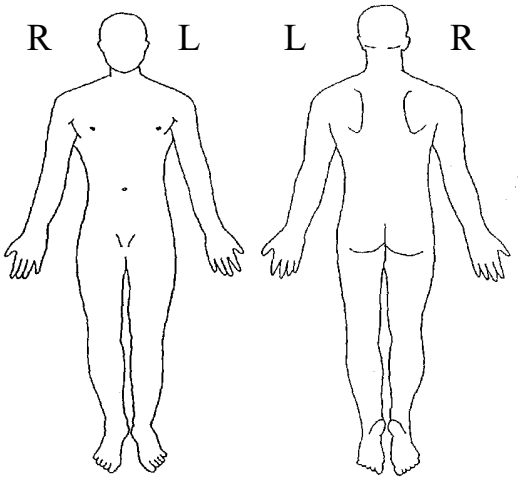
Have you had any previous treatment for this, and if so what sort?

.....

Please list any other health conditions that are currently concerning you.

1. .....
2. .....
3. .....
4. .....

Please shade in affected areas:



Have you ever had ***chiro*** or ***physio*** treatment before (please circle which), and if so, what approximate date of your most recent visit & the practitioner's name?.....

Are you currently taking any medication, and if so, what? .....

Are you currently taking any vitamins or natural remedies, and if so, what? .....

Do you smoke, and if so, approximately how many per day?.....

What sports / physical activities are you involved in?.....

Have you ever had spinal X-rays taken, and if so when? .....

Do you (or have you in the past) suffered any of the following? Please circle:

Frequent Headaches	Migraines	Cancer	Major Surgery
Stroke or T.I.A.	Thrombosis or D.V.T	Osteoporosis	Blood Clotting Disorder
Excessive Fatigue	Spinal Fracture	Constipation	Asthma
Diabetes	Heart Disease	High Blood Pressure	Depression
Anxiety	Ringing in the Ears	Stomach Reflux	Prostate Trouble
Eye Disease	Dizziness/Vertigo	Arthritis	Schizophrenia
Bone or Joint Disease	Menopausal Symptoms	Severe Period Pains	Irregular Periods
HIV/Aids	Hepatitis	Bipolar disorder	Psoriasis

Any other major conditions.....

Signature of Patient (or parent/guardian)..... Date ..... / ..... / .....