TOTAL LIFESTYLE
chiropractic

Confidential Patient Information

Full Name _____ Date _____

Address _____

_____

Postal Address (if different) _____

_____

Telephone **H** _____ **M** _____ **W** _____

Email _____

Date of Birth _____ Occupation _____

Next of Kin _____ Contact Number _____

Medicare Number _____ Ref _____

Name of Health Fund (if applicable) _____

How did you hear about us? Google ☐ Facebook ☐ Sign ☐ Newspaper ☐ Phone Book ☐

Friend / Family ☐ → Who? _____

Previous Chiropractor's Details

Name _____

Town City _____ Date of Last Visit _____

What caused you to seek Chiropractic Care? _____

Did the Chiropractor take X-Ray's? Yes ☐ No ☐ Did the you have a thorough examination? Yes ☐ No ☐

What were the results of your care? Excellent ☐ Satisfactory ☐ Fair ☐ Did not help ☐ Worsened ☐

Medical Provider's Details (G.P)

Name _____

Town City _____ Date of Last Visit _____

Clinic Name _____ Telephone _____

16 Begley Street | PO Box 1216, Airlie Beach QLD 4802
☎ (07) 4946 7111 ✉ airliebeach@tlcaustralia.com

What brings you to our practice?

When did this occur? **Was this the result of an injury?** Yes No

How often are you experiencing discomfort from the complaint? Rarely Comes & Goes Constant

Since the first time it happened, is the complaint Staying the Same Getting Better Getting Worse

Describe your complaint: Achy Dull Tingling Numbness Crushing Tightness Throbbing
Burning Sharp Stabbing Shooting Other

Does the complaint radiate anywhere? If so, where?

Which of the following activities aggravate your complaint?

Bending Reaching Coughing Standing Sneezing Walking Lifting Sitting
Other (please describe)

Is this complaint interfering with any of the following?

Work Sleep Daily Tasks Driving Sport/Exercise Hobbies Leisure
Other (please describe)

Previous care for this compliant or condition: (please tick)

Chiropractor	GP	Orthopaedic Surgeon	Specialist
Physiotherapist	Osteopath	Massage Therapist	Medication

Please rate the following on a scale of 1 — 10

Current overall health	1	2	3	4	5	6	7	8	9	10	
Diet / Eating Habits	1	2	3	4	5	6	7	8	9	10	
Fitness / Exercise Habits	1	2	3	4	5	6	7	8	9	10	
Stress at work	1	2	3	4	5	6	7	8	9	10	
Stress at home	1	2	3	4	5	6	7	8	9	10	
Sleep	1	2	3	4	5	6	7	8	9	10	

What do you hope to achieve from chiropractic care?

Relieve Discomfort	Increase Flexibility	Exercise More	Return to Normal Activity
Improve Posture	Increase Strength	Reduce Stress	Perform Better at Sport
Improve Diet	Other (please specify)		

What is your passion in life? (Hobbies / Special Interests)

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Medical History

Have you ever suffered from any serious health problems? Yes ☐ No ☐ Unsure ☐

Have you ever been involved in a motor vehicle accident or major fall? Yes ☐ No ☐ Unsure ☐

If Yes, please describe what & when

Have you ever undergone surgery or been hospitalised? Yes ☐ No ☐ Unsure ☐

If Yes, please describe what & when

Have you ever fractured or broken any bones? Yes ☐ No ☐ Unsure ☐

If Yes, please describe what & when

Are you a smoker? Yes ☐ No ☐ I Quit ☐ **Do you drink alcohol?** Yes ☐ No ☐ I Quit ☐

Are you currently taking any of the following medication?

Anti-inflammatory ☐	Muscle Relaxants ☐	Other (please list)
Anti-depressants ☐	Pain Killers ☐	
Birth Control ☐	Cholesterol (Statins) ☐	
Vitamins ☐	Hormone Replacement ☐	
Steroids ☐	Blood Pressure ☐	

Do you currently, or have you ever suffered from any of the following?

Back Discomfort ☐	Constipation ☐	Headaches ☐	Muscle Weakness ☐
Blurred Vision ☐	Diarrhoea ☐	Ingestion / Reflux ☐	Persistent Cough ☐
Bowel Problems ☐	Depression ☐	Loss of Balance ☐	Pins & Needles ☐
Bladder Problems ☐	Dizziness ☐	Nausea / Vomiting ☐	Speech Difficulty ☐
Chest Discomfort ☐	Fatigue ☐	Numbness ☐	Stiffness ☐

Allergies (please list)

Family History

In our office we are not only interested in your health & wellbeing, but also that of your family. Additionally, family history holds significance importance given the congenital relationship of certain conditions that can be inherited. Please mention below any health conditions or concerns you may have about your family.

Mother **Father**

Spouse **Children**

Others

For Women

Are you pregnant? Yes ☐ No ☐ Unsure ☐ **Date of last menstrual cycle**

Do you experience any of the following symptoms?

Tender Breasts ☐	Bleeding between periods ☐	Irregular periods ☐
Hot flushes ☐	Discomfort during intercourse ☐	Vaginal discharge ☐
Period discomfort ☐	Excessive menstrual flow ☐	Lumps in breast(s) ☐

Please read & sign

The information that I have provided on this form is accurate and truthful to the best of my knowledge. I consent to further evaluation at this office via a professional and thorough chiropractic, orthopaedic and neurological examination.

Print your name **Date**

Signature

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