PATIENT HISTORY REPORT

(Please Print)

CONFIDENTIAL

Date: ………………..

Your Full Name: ………………………………………………………………Your birthdate: ………/………/…………
Address: …………………………………………………………………………… Phone (H): (…..)…………………………………
……………………………………………… Postcode: …………………Phone (W):(….)………………………………
Postal address:………
Mobile:…………………………………………Email:……………………………………………………………………

What are you expecting from your first visit today? ……………………………………………………………
……
……

Do you have a **pension card**? Yes / No

Does your **private health insurance** cover chiropractic? Yes / No

Name of Private Health Insurance provider …………………………………………………………………………

Have you had **previous chiropractic care**? Yes / No

If Yes – My previous Chiropractic Care was by DR. ……………………………………at……………………………
My last Chiropractic Adjustment was on ……/……/……

I would like help for ………………………………………………………………………………………………
……
……
……

Other problems I am concerned with ……………………………………………………………………………
……
……

Car accident(s) When? Injuries? …………………………………………………………………………………
……
……

Other personal injuries When? Injuries? ……………………………………………………………………
……
……

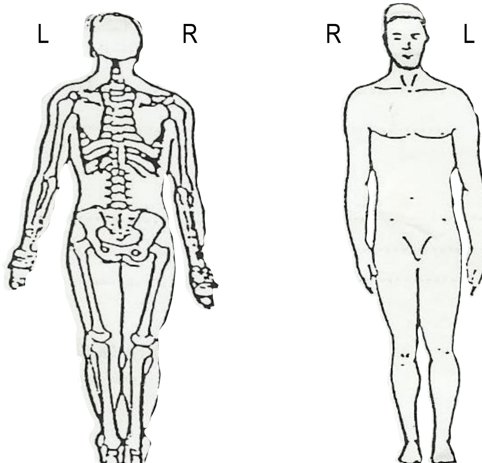
Exercise programs / sporting activities
……………………………………………………………………………
……………………………………………………………………………
……………………………………………………………………………

Do you wear any supports? Back / Foot etc
……………………………………………………………………………
……………………………………………………………………………

Operations? ……………………………………………………………
……………………………………………………………………………
……………………………………………………………………………
……………………………………………………………………………

Drugs / medicines / vitamins – Type / Dosage etc?
……………………………………………………………………………
……………………………………………………………………………
……………………………………………………………………………

Please mark the affected areas by circling / marking them in red.



I understand that no accounts are rendered by Farmer Chiropractic and my payment at the time of my first visit will be

Cash ❑ Cheque ❑ Credit Card ❑ Eftpos ❑

I have been recommended to this clinic by DR / MR / MRS ………………………………….

❑ Family ❑ Friend ❑ Sign ❑ Website ❑ Telephone Directory

Your hobbies / interests: ………………………………………………………………………………………………………
………
………

PLEASE TICK APPRO. BOX

❑ Married
❑ Single
❑ Widow/er
❑ Divorced
❑ Defacto

Your type of work: ……………………………………………………..
Your employer: ………………………………………………………….
Employment address: ……………………………........................
is this a worker's compensation case? …………………………..

No. of Children: ………..

Your Height: ……………….. Your Weight: ………………..

To help us better understand your health goals:

What is your ultimate health goal by attending this Chiropractic Clinic?
………
………
………
………
……

Thank you for completing this form. We look forward to working with you to see you enjoy your life and reach your health goals.