BURSLEM MEDICAL
centre

Address: 1/201 Burslem Drive
Phone: 08 9452 0300

Date:_____

PERSONAL INFORMATION

Name: _____

Sex: Male☐ Female☐

Age: _____ Date of Birth (DD/MM/YY): _____

Marital Status: _____

Address: _____

City: _____

Postal Code: _____

Phone #: (Home) _____ (Work) _____ (Mobile) _____

Email Address: _____

Employer: _____

Occupation: _____

Referred By: _____

Have you been to a chiropractor before? Y / N When was your last treatment? _____

Medical Doctor: _____

Date of Last Appointment or Physical: _____

ADDRESSING THE ISSUE THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or complaints, and are here for wellness care, please check here ☐

If you are symptomatic, please complete the following:

Please describe your present complaint: _____

_____

When did it occur? _____ How did it occur? _____

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Have you ever had this before? Y□ N□ If yes, when? _____

Is the problem there – all the time□ comes and goes□

Is the problem getting – worse□ no change□ better□

Does the pain travel anywhere? _____

Please describe how the pain feels: _____

Does coughing, sneezing or straining aggravate the pain? Y/N

What makes it worse? _____

What makes it better? _____

Have you received any treatment for this condition, and if so what kind of treatments?

_____

Has any treatment helped? _____

Were X-rays taken? Y□ N□
Please indicate the amount of pain/discomfort associated with your problem(s)

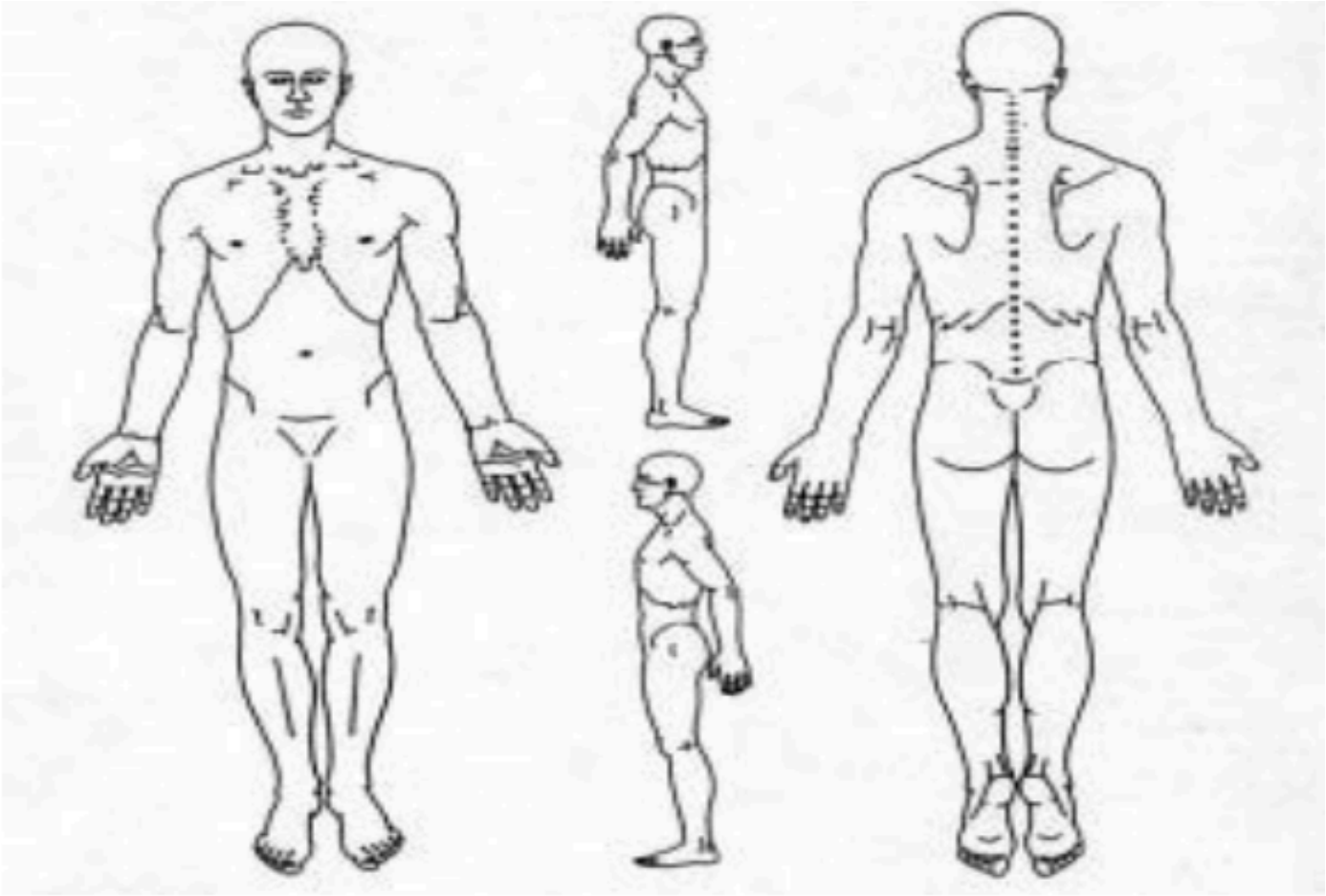
No pain I---I---I---I---I---I---I---I---I---I---I Worse pain ever
0 1 2 3 4 5 6 7 8 9 10

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Please use the symbols below to mark and describe each type of problem on the body diagrams.

Sharp/Stabbing pain XXXX
Dull ache OOOO
Numbness nnn
Stiff/Tightness ////
Tingling ttt
Burning ++++



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HAVE YOU EVER:

Had an accident (car, fall, sports, other)? Y□ N□

If yes, please describe: _____

_____

Had an operation? Y□ N□ If yes, please describe: _____

Had a fracture? Y□ N□ If yes, please describe: _____

Been hospitalized? Y□ N□ If yes, please describe: _____

FAMILY HISTORY

Have your grandparents, parents or siblings ever been diagnosed with any of the following?

□High blood pressure
□Heart disease
□Stroke
□Diabetes (Type I or Type II)
□Thyroid / Hormone problems
□Breathing or lung problems
□Rheumatoid Arthritis
□Osteoarthritis
□Neurological problems
□Cancer
□Kidney Disease
□Other specify:_____

ARE YOU TAKING ANY OF THE FOLLOWING?

□Anti-inflammatories
□Antibiotics
□Insulin
□Sedatives
□Aspirin/Analgesics
□ Antacids
□Muscle relaxants
□Birth control pills
□ Vitamins/Herbs

Other:
_____

LIFE STYLES

Smoking _____ packs/day Alcohol _____ drinks/week

Coffee/tea/caffeinated beverage _____cups/day

Exercise _____times/week Sleep_____hours/day on back□ side□ stomach□

Your stress level can be described as: Minimal□ Moderate□ Severe□ Intolerable□

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Medical History- Please check ☑ the appropriate symptoms or conditions that you are experiencing now. Mark any condition you previously had with an ☒.

GENERAL
☐Allergy
☐Weight loss
☐Weight gain
☐Skin irritations
☐Sweats
☐Tremors
☐Chills
☐Fever

NEUROLOGICAL
☐Convulsions
☐Dizziness
☐Nausea
☐Numbness
☐Tingling sensation
☐Nervousness/Depression
☐Burning Sensation
☐Headaches
☐Muscle Weakness

GENITO-URINARY
☐Kidney stones
☐Urinary tract infections
☐Painful urination
☐Frequent urination
☐ Inability to control urination

MUSCLE AND JOINT
☐Shoulder
☐Mid-back pain/stiffness
☐Knee
☐Hip
☐Elbow
☐Neck pain/stiffness
☐Ankle
☐Spinal curvature
☐Hand/wrist
☐Low back pain/stiffness
☐Foot

CARDIOVASCULAR
☐Hardening of Arteries
☐Poor circulation
☐High Blood Pressure
☐Cold extremities
☐Swelling of ankles
Other Problems in the these areas (specify):_____
_____

GASTROINTESTINAL
☐ Gall bladder
☐Liver trouble
☐Vomiting of blood
☐Hernia
☐ Blood in stool
Other digestive problems (specify):_____
_____

EYES, EARS, NOSE AND THROAT
☐Enlarged glands
☐Deafness/hearing loss
☐Enlarged thyroid
☐Trouble speaking
☐Problems swallowing
☐Falls due to poor balance
☐Blurred vision
Other Problems in the these areas (specify):_____

RESPIRATORY
☐ Chest pain
☐ Difficult breathing
☐Spitting up blood
☐ Asthma
☐ Coughing
Other Problems in the these areas (specify):_____

FOR WOMEN ONLY
☐Hot flashes
☐Irregular cycle
☐Menopausal symptoms
☐Lumps in breasts
☐Are you pregnant? YES☐ NO☐
Other gynecological problems (specify):_____
_____

OTHER (Specify):
_____
_____
_____
_____
_____
_____
_____
_____

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Circle the following conditions you presently have or have had in the past.

Alcoholism	Emphysema	Polio
Anemia	Epilepsy	Rheumatic fever
Arteriosclerosis	Gout	Stroke
Arthritis	Heart disease	Tuberculosis
Cancer	Osteoporosis	Ulcers
Diabetes	Pneumonia	Other (specify):_____

Signature_____ Date_____