Peak Performance Chiropractic & Rehabilitation Clinic P/L

Patient Intake & History Form

Examiner: ………………………

Name ………………………………………………………………………………………**Paient-ID**:……………………………………**Date**…………………………………

DOB……………………………………………………………………………………………**Gender:** **M**☐ **F**☐

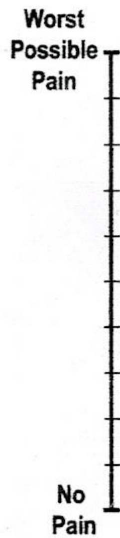
Address:………

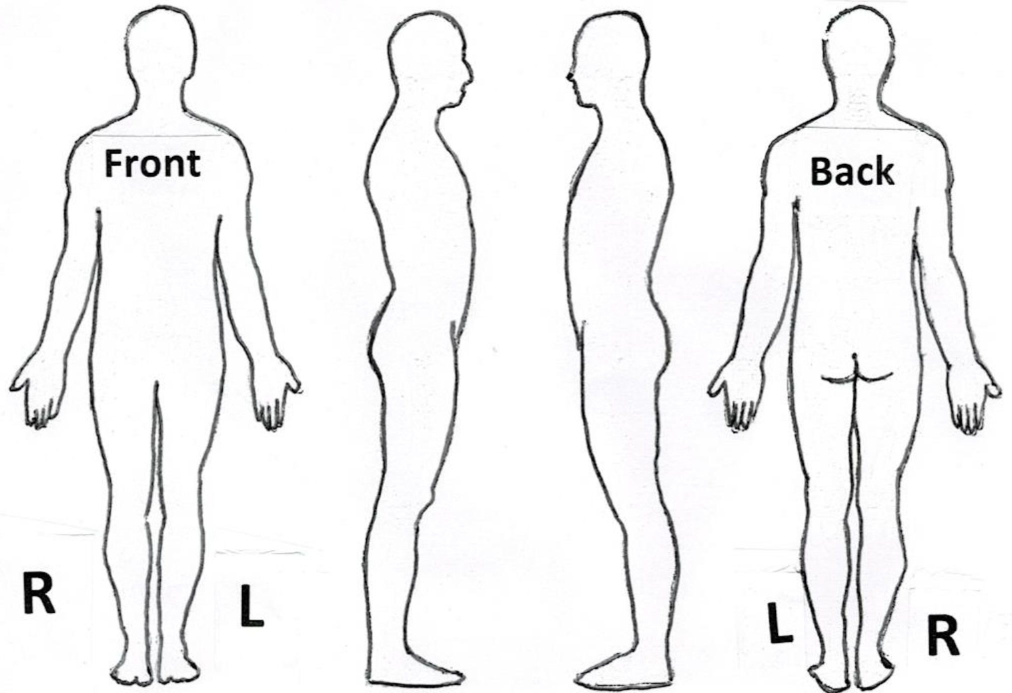
Mobile:…………………………………………. **Email:** ……………………………………………………. **Work or Home phone**:……………………………………

Name of parent/guardian……………………………………………. **Name/Suburb of GP**………………………………………………………………………

What is the reason for coming today? (Please briefly describe your symptoms)

Main complaint	Additional complaint
Location (also use drawing)	





Onset (how –when)	
Pain (sharp or aching, constant or intermittent…)	
Intensity (out of 10, best and worst)	

What makes it better or worse	
Do you have pins & needles, pain or numbness in arms or legs?	
Have you ever had it before?	
Have you received any treatment (by who and when) ? Have you taken any medication so far?	
Have you had any imaging (x-ray, MRI etc) done?	
Has it got worse over the last four weeks?	
Does it keep you from doing anything? Does it keep you awake or wake you up at night?	
What do you think might be causing the problem?	

What are your treatment goals? …….

Past Health Hx:

Injuries/trauma/accidents	Illnesses/surgeries
Hereditary disease/family health problems	Contraceptives / medication

Children/ pregnancies…….

Personal/social history

Living situation	Occupation
Exercise (type, frequency)	Sleep pattern (wake rested ?)
Bowel movements (daily ? / constipated ?)	Urinary habits (frequency / pain on passing urine ? / blood in urine ?)
Alcohol, tobacco, drugs	Stress factors

Vascular Risk

Dizziness……………………..Double vision…………………………Dysphagia………………………..Dysarthria…………………………Drop attacks……………………………

Numbness…………………………Nausea…………………………Visual disturbances……………………LOC…………………………………Ataxia……………………………………..

New Headaches………………