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WELCOME TO HEALTHSPACE AND THANK YOU FOR CHOOSING US!

○ MR ○ MRS ○ MS ○ DR FULL NAME GENDER: M / F

ADDRESS SUBURB & POSTCODE

Phone: HOME MOBILE WORK

D.O.B.: Email Address:

OCCUPATION: MARITAL STATUS: M S W D PARTNER NAME:

PREGNANT? Y / N NAMES & AGES OF CHILDREN:

PRIVATE HEALTH FUND: MEDICARE NUMBER:

GENERAL PRACTITIONER:

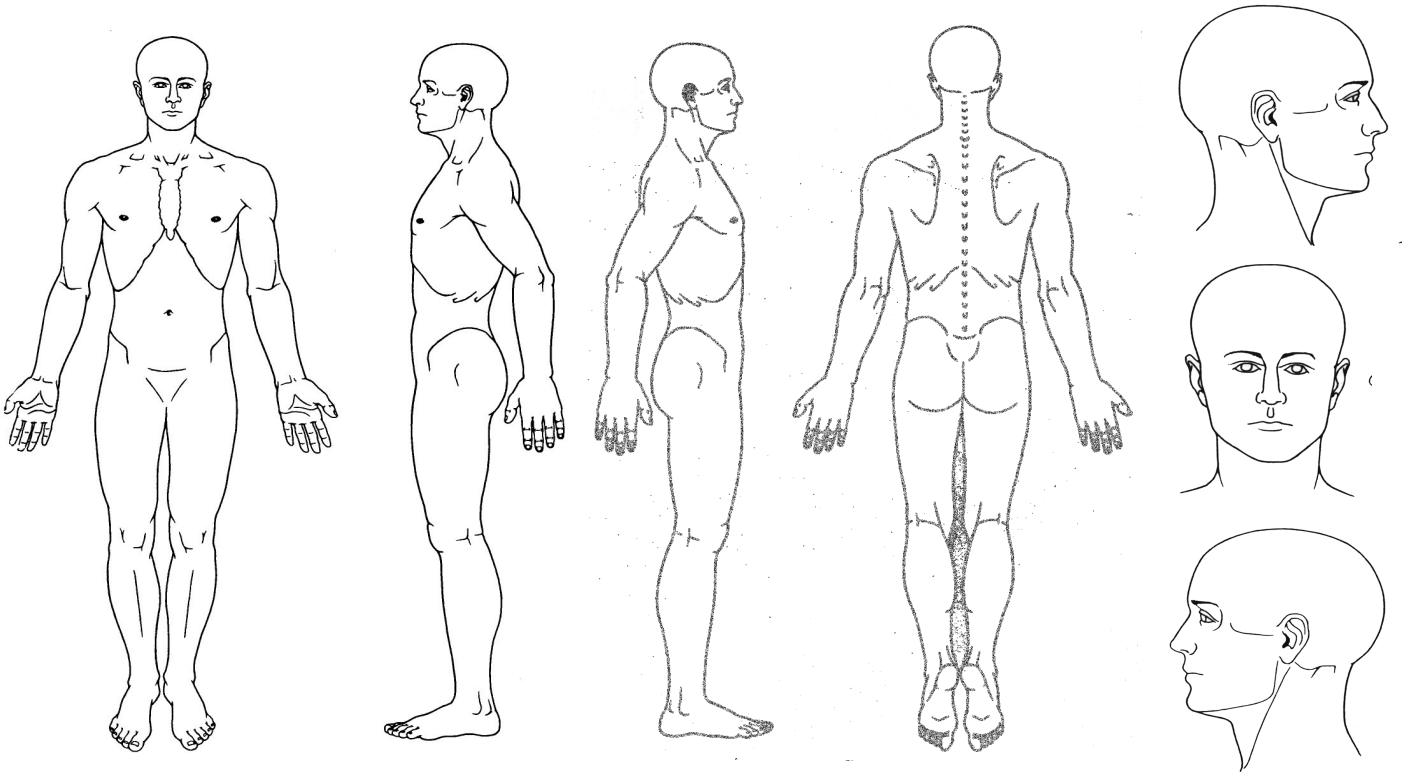
GP ADDRESS & PHONE NUMBER:

Who can we thank for referring you to Health Space?

Addressing what brought you into this office:
*If you have no symptoms or complaints and are here for a general tune up, please skip to the **"General Health History"** on page 2.*
Health Concerns

Please list your health concerns	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this Condition before, When?	Do you know what caused the problem?
1.				
2.				
3.				

Please mark on the diagram below where you are experiencing discomfort and pain, or have an injury:



Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started, is it: About the same? ○ Getting better? ○ Getting worse? ○
What have you done for this condition? Was it of benefit?

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Which activities aggravate your condition? .....

Other doctors you have seen for this condition? .....

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc.? (i.e. eat better, less alcohol/drugs, meditate or breathe more, less destructive sports/activities, etc.) If so, what? .....

.....

Is this condition interfering with any of the following?

○ Work	○ Sleep	○ Daily Routine	○ Sports/Exercise	○ Other (please explain):

GENERAL HEALTH HISTORY

Often, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us to help you!

Have you had surgery? (Please include all surgeries)

1. Type: When?

2. Type: When?

Do you wear orthotics or heel lifts? .....

Past Health History

Please mark the following conditions you may have had or have now (**-** have had, or **+** have now):

○ Alcoholism	○ Allergy	○ Anaemia	○ Arteriosclerosis	○ Arthritis	○ Asthma	○ Back Pain
○ Cancer	○ Cold Sores	○ Constipation	○ Convulsions	○ Depression	○ Diabetes	○ Diarrhoea
○ Eczema	○ Emphysema	○ Epilepsy	○ Gall Bladder Problems	○ Gout	○ Headaches	○ Heart Attack
○ Heart Disease	○ High Blood Pressure	○ HIV (AIDS)	○ Irregular Periods	○ Low Blood Pressure	○ Malaria	○ Measles
○ Menstural Cramps	○ Migraines	○ Miscarriage	○ Multiple Sclerosis	○ Mumps	○ Nervousness	○ Neuritis
○ Pleurisy	○ Pneumonia	○ Polio	○ Rheumatic Fever	○ Ringing in Ears	○ Sexually Transmitted Infection	○ Sinus Problems
○ Stroke	○ Thyroid Problems	○ Tuberculosis	○ Ulcers	○ Whooping Cough		

Other (please explain) .....

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past six months and why: (prescription and non-prescription)

.....

.....

Please list all nutritional supplements, vitamins, homoeopathic remedies you presently take and why?

.....

.....

Are you interested in knowing more about how your nutrition affects your overall health and wellbeing?	○ Yes ○ No ○ Maybe
If dietary changes were indicated, would you be willing to make changes in your diet?	○ Yes ○ No ○ Maybe

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Stressors

Because accumulation of stress affects our health and ability to heal, please list your top two stresses (that you have ever had) in each category below:

1. Physical Stress (falls, accidents, work postures, etc.)
   A.....
   B.....
2. Bio-chemical Stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   A.....
   B.....
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   A.....
   B.....

On a scale of 1-10 (1 being poor and 10 being excellent), please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, please describe your:

Eating Habits:	Exercise Habits:	Sleep:	General Health:	Mindset:

What are your short term health goals?

.....

What are your long term health goals?

.....

At Health Space we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. The risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimised through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let the chiropractor know.

I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns they can be discussed with the chiropractor. I appreciate that I will receive the best care possible at Health Space but that results cannot be guaranteed.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor seems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Patient Signature ..... Date ...../...../.....

Your information is private and confidential, however we may need to correspond with various third parties, including your GP, specialist or insurance company.

Health Space provides an appointment reminder service by SMS and may also communicate with you by SMS and email from time to time.

All clients are automatically enrolled in this service. If you do not wish to have this service please indicate below:

○ Please do not send me appointment reminders by SMS.

○ Please do not send me Health Space updates by email.