

Patient Acquaintance Form



Welcome to Body Brilliant Chiropractic. All information is strictly confidential.
If you need help with a question, please feel free to ask one of our friendly team.

Full name _____ Date _____

Postal address _____

Postcode _____

Telephone H _____ W _____ M _____

E-mail _____ Date of Birth _____ Age _____

Spouse/guardian name _____ Marital Status S M D/F D W

Children's Names and Ages/Members of your household _____

Occupation _____ Employer _____

How many hours per day at work/daily routine do you spend sitting _____ standing _____

Who can we thank for referring you/ where did you find out about us? _____

Do you have a Medicare card? Yes / No Do you agree to an X ray examination of your spine if required? Yes / No

Why have you come to see us?

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "Vital Health Profile"

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = excruciating	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Since the problem started is it? About the Same Getting Better Getting Worse

When is it worst /what aggravates it? _____

When is it better / what relieves it? _____

What previous care have you had and was it of benefit? ("Relief" Chiropractor - focuses mainly on neck and back pain, "Wellness" Chiropractor - focuses on health and well being as well as underlying cause of pain and health concerns, physio, massage, GP, medication, etc)

Does your current health condition interfere with any of the following?

Household duties Exercise/Sports Relationships

Work Sleep Daily Routine

Does it cause you to be?

Moody or Irritable Fatigued or Exhausted Less Productive or Make Poor Decisions

Other (please explain) _____

Vital Health Profile

Please mark the following conditions you have experienced in the past with or have now with

Neck Pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Recurrent colds/flu	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Low Energy	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Sleeping Difficulty	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Urinary Infection	<input type="checkbox"/>

Ladies

Menstrual Problems Menopausal Problems Infertility Pregnant

Gentlemen

Prostate Problems Impotence Infertility (Weeks) _____

Please list any supplements you take and why

Please list any medications you take and why (prescription and 'over the counter')

Stressors

Accumulation of life's stress affects both our health and our ability to heal. Please list the top 3 stressors (you have ever had) in each category.

Physical Stress (falls, accidents, poor postures, work, sports injuries, motor vehicle accidents, repetitive strains, etc)

1. _____
2. _____
3. _____

Please provide details of any motor vehicle accidents you have been involved in (you may not have been driving)

1. Type _____ When _____ Speed _____
2. Type _____ When _____ Speed _____
3. Type _____ When _____ Speed _____

Have you ever had X rays taken?

Area of body _____ When _____ Reviewed by Wellness Chiropractor? Y / N

Area of body _____ When _____ Reviewed by Wellness Chiropractor? Y / N

Have you ever been hospitalised? (Please include all surgery)

1. Why _____ When _____ Where _____
2. Why _____ When _____ Where _____

Bio-chemical Stress (smoke, processed/fatty foods, missed meals, not enough water, drugs/alcohol, medications, electromagnetic radiation from computers/TV's/mobiles, flavoured fizzy drinks, toxin exposure, etc)

1.
2.
3.

Mental or Emotional Stress (work, relationships, loss of loved ones, finances, study/exams, self-esteem, traffic, anxiety, depression, etc)

1.
2.
3.

How would you grade your current level of health? (very poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

What importance do you place on your health & wellbeing? (none) 1 2 3 4 5 6 7 8 9 10 (most)

What is your desired outcome from your chiropractic care?

Wellness Care and Optimal Health Relief care only Spinal check up

Other (please explain) _____

If we could help you improve any other areas of your life, which of these would they be?

- | | | |
|--|--|---|
| Energy Levels <input type="checkbox"/> | Digestion <input type="checkbox"/> | Quality of Sleep <input type="checkbox"/> |
| Bowel Function <input type="checkbox"/> | Breathing <input type="checkbox"/> | Immunity <input type="checkbox"/> |
| Concentration <input type="checkbox"/> | Cope with Stress <input type="checkbox"/> | Balance <input type="checkbox"/> |
| Co ordination <input type="checkbox"/> | Quality of Life <input type="checkbox"/> | Happier <input type="checkbox"/> |
| Flexibility <input type="checkbox"/> | Muscle Strength <input type="checkbox"/> | Bladder Function <input type="checkbox"/> |
| Muscle Tension <input type="checkbox"/> | Mental Creativity <input type="checkbox"/> | Performance <input type="checkbox"/> |
| Exercise Recovery <input type="checkbox"/> | Hormone Balance <input type="checkbox"/> | Weight Control <input type="checkbox"/> |

Are you interested in knowing more about how your nutrition (food you eat) may affect your problem, as well as your overall health and well-being? Yes No

Would you make dietary changes or take whole food supplements if indicated? Yes No

If specific tailored exercises and stretching is indicated to help you, are you likely to do them to receive the full benefit? Yes No

If reducing stress is indicated to help you would you like to know ways to reduce stress? Yes No

Is there anything else which may help us to understand how you're feeling?

Thank you for your time to assist us with assessing your case. Your health and recovery are extremely important to us. Due to the unique nature of the care we provide here, it is our centre policy that your spouse (if applicable) must be in attendance for your report of findings.

I have read and understand the need for my spouse to be in attendance at my report of findings and the above information is true and correct to the best of my knowledge.

Signed _____ Date _____