BodyWise CHIROPRACTIC

Welcome to BodyWise Health.

Please take the next few minutes to complete this form to provide important information so we can help you get the most from your Chiropractic care.

PATIENT DETAILS					
First Name		Surname			
Phone		Mobile			
Email					
Address					
Suburb		Postcode		State	
Occupation		D.O.B.	/ /	Age	
Spouse's Name		Spouse's Occupation			
No. of Children		Ages			

HOW MANY HOURS PER DAY / AT WORK / IN DAILY ROUTINE DO YOU SPEND…			
Sitting		Standing	

REGULAR GP DETAILS			
Name of GP		Permission to Contact?	Yes / No
Name of Clinic (If Applicable)			
GP Clinic Address			
Phone No.			

MEDICAL COVER				
Medicare Card	Yes / No	Do you agree to an x-ray examination of your spine if required?		Yes / No
Private Health Insurance	Yes / No	If so, Please Name the Provider		

WHO CAN WE THANK FOR REFERRING YOU? / WHERE DID YOU FIND OUT ABOUT US? (PLEASE TICK)

Facebook ☐ Google ☐ Friend ☐ Colleague ☐ Other ☐ Please Specify: eg.BNI

WHY HAVE YOU COME TO SEE US?					
If you have no symptoms or complaints and are here for Wellness Services, please skip to **"Vital Health Profile"** Please list your health concerns according to their severity	Rate the 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 time pain is present
1					
2					
3					
4					

VITAL HEALTH PROFILE Please mark the following conditions you have experienced in the past with ☒ or have now with ☑							
	Neck Pain		Headaches / Migraines		Low Energy		Thyroid Problems
	Allergies		Numbness		Sinus Problems		Epilepsy
	Depression		Anxiety		Ringing in the Ear		Asthma
	Sleeping Difficulties		Mid Pain Back		Breathing Problems		Heart Disease
	Visual		Low Back Pain		Heart Attack		Recurrent Cold / Flu
	High Blood Pressure		Chest Pains		Digestive Problems		Arthritis
	Ear Infections		Cancer		Diabetes		Stroke
	Eczema		Incontinence		Multiple Sclerosis		Infertility
	Urinary Tract		Learning Difficulties		Dizziness		Visual Disturbances
	Menstrual (f)		Menopausal Problems (f)		Currently Pregnant (f)- Specify How Many Weeks:		
	Prostate (m)		Impotence (m)				

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 AND WELLBEING?											
None	1	2	3	4	5	6	7	8	9	10	Essential

WHAT IS YOUR DESIRED OUTCOME FROM YOUR CHIROPRACTIC/MASSAGE CARE?

- ☐ Wellness care and optimal health
- ☐ Relief care only
- ☐ Spinal check-up, other (please specify)

IF WE COULD HELP WITH OTHER AREAS OF YOUR LIFE WHAT WOULD THEY BE? (*MARK WITH X)*					
	Energy Levels		Bowel Function		Concentration
	Co-ordination		Flexibility		Muscle Tension
	Exercise Recovery		Digestion		Breathing
	Cope with Stress		Quality of Life		Muscle Strength
	Hormone Balance		Quality of Sleep		Immunity
	Happier Moods		Bladder Function		Weight Control
	Other (Please Specify)				

PATIENT DECLARATION:

The above information is true and correct to the best of my knowledge.

Signed		Date	