

WELCOME TO HEALTHSPACE AND THANK YOU FOR CHOOSING US!

☐ MR ☐ MRS ☐ MS ☐ DR

FULL NAME

Date:

ADDRESS

PHONE: HOME

MOBILE

WORK

EMAIL ADDRESS

DATE OF BIRTH

OCCUPATION

MARITAL STATUS: M S W D

SPOUSE NAME

PREGNANT? Y / N

NAMES & AGES OF CHILDREN

PRIVATE HEALTH FUND

GENERAL PRACTITIONER

GP ADDRESS & PHONE NUMBER

Who can we thank for referring you to HealthSpace?

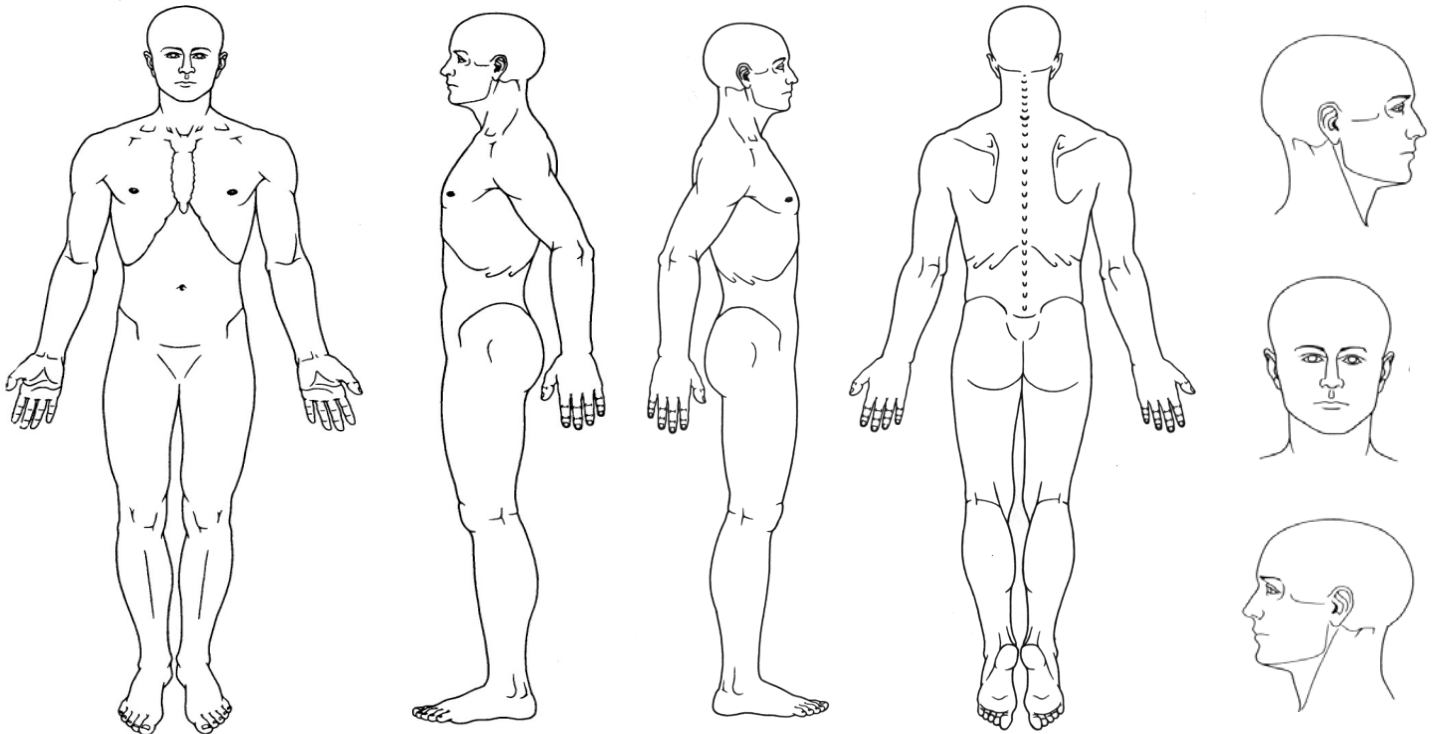
### Addressing what brought you into this office:

If you have no symptoms or complaints and are here for 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 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?

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?

<input type="radio"/> Work	<input type="radio"/> Sleep	<input type="radio"/> Daily Routine	<input type="radio"/> Sports/exercise	<input type="radio"/> Other (please explain):
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## GENERAL HEALTH HISTORY

*Often times, 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 help you!*

Have you had surgery? (Please include all surgery)

1. Type: ..... When?

2. Type: ..... When?

Do you wear orthotics or heel lifts? Y / N

## Past Health History

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

<input type="radio"/> Alcoholism	<input type="radio"/> Allergy	<input type="radio"/> Anaemia	<input type="radio"/> Arteriosclerosis	<input type="radio"/> Arthritis	<input type="radio"/> Asthma	<input type="radio"/> Back Pain
<input type="radio"/> Cancer	<input type="radio"/> Cold Sores	<input type="radio"/> Constipation	<input type="radio"/> Convulsions	<input type="radio"/> Depression	<input type="radio"/> Diabetes	<input type="radio"/> Diarrhoea
<input type="radio"/> Eczema	<input type="radio"/> Emphysema	<input type="radio"/> Epilepsy	<input type="radio"/> Gall Bladder problems	<input type="radio"/> Gout	<input type="radio"/> Headaches	<input type="radio"/> Heart Attack
<input type="radio"/> Heart Disease	<input type="radio"/> High Blood	<input type="radio"/> HIV (AIDS)	<input type="radio"/> Irregular	<input type="radio"/> Low Blood	<input type="radio"/> Malaria	<input type="radio"/> Measles
<input type="radio"/> Menstrual Cramps	<input type="radio"/> Migraines	<input type="radio"/> Miscarriage	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Mumps	<input type="radio"/> Back Pain	<input type="radio"/> Nervousness
<input type="radio"/> Neuritis	<input type="radio"/> Pleurisy	<input type="radio"/> Pneumonia	<input type="radio"/> Polio	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Ringing in ears	<input type="radio"/> Sinus Problems
<input type="radio"/> Stroke	<input type="radio"/> Thyroid Problems	<input type="radio"/> Tuberculosis	<input type="radio"/> Ulcers	<input type="radio"/> Venereal Disease	<input type="radio"/> 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 supplement, 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 <input type="radio"/>	No <input type="radio"/>	Maybe <input type="radio"/>
If dietary changes were indicated would you be willing to makes changes in your diet?	Yes <input type="radio"/>	No <input type="radio"/>	Maybe <input type="radio"/>

## Stressors

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

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 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being poor and 10 being excellent) please describe your:

Eating Habits:	Exercise Habits	Sleep:	General Health:	Mind set:
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What are your short term health goals?

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What are you long term health goals?

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At HealthSpace 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 healthcare 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 your Chiropractor know.

I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns, these can be discussed with my Chiropractor. I appreciate that I will receive the best care possible at HealthSpace but that results cannot be guaranteed.

I consent to a professional and complete Chiropractic examination and to any radiographic examination that the doctor deems 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 ...../...../..... Witness .....

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

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

HealthSpace 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 and communications by SMS or email.