

CLIENT CONFIDENTIAL QUESTIONNAIRE

Please complete this form to the best of your knowledge for answers you provide gives us a clear understanding about how we can assist your concerns better.

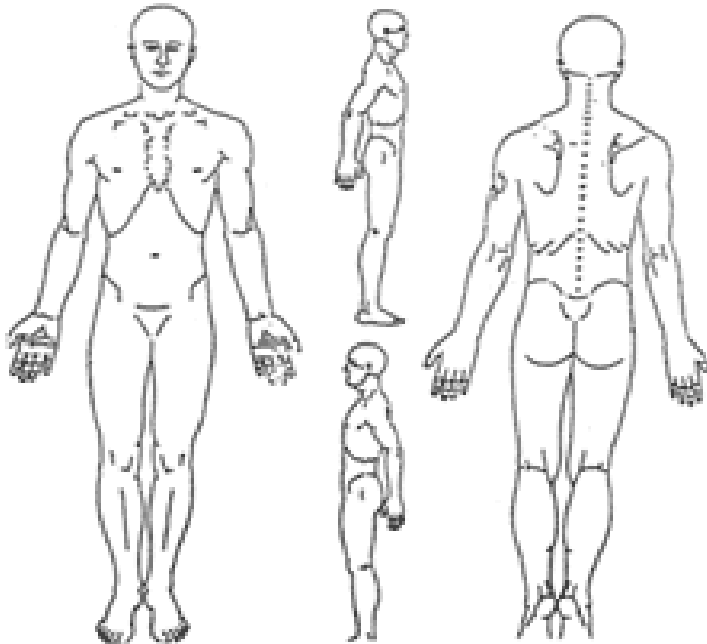
First Name:	Surname:	Gender: M / F
Address:	Postcode:	State:
(T)Home:	Work:	Mobile:
Email:	Health Fund (Private):	Marital Status:
Birthdate:	Age:	Occupation:
How did you hear about us?	Family	Friend
	Internet	Close to Home
	Other:	

IN CASE OF EMERGENCY

Name:	Relationship:	Mobile:
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Please Specify your Family Physician Details (if any):

Name:	Contact Details:
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Use the letters to indicate the LOCATION and TYPE of problem:	
P – Pain	S – Stiffness
A – Ache	B – Burning
N – Numbness	W – Weakness
H – Heat	C – Cold
T – Tingling	X – Other

Other: _____

Is this a WorkSafe Claim: Yes/No

Is this a TAC Claim: Yes/No

If Yes, claim number: _____

Insurance Company? _____

Please list your MAJOR concerns:

Please list ANY OTHER complaints or concerns:

List every fall/accident/motor vehicles/fractures/dislocations:

List any surgery procedures and year:

Have you had any Imaging Done?

CLIENT HISTORY

Details:	Have you had this before?		
How did it occur?			
<i>Notes: Sudden/Gradual/Daily/Nightly/Intermittent/Recurring/Wake you at night/Other</i>			
When did you first notice it?	How long have you had this?		
Pain Character? Sharp/Dull/Stabbing/Ache/Throbbing/Tingling/Referring/Radiation/Throbbing/Hot/Cold/Searing			
<i>Notes:</i>			
What makes it worse?	Pain Scale 1-10 (0 no pain 10 being worse): /10		
What makes it feel better?			
<i>Notes:</i>			
Has it Improved/unchanged/gotten worse?			
Previous treatments:			
<i>What kind of treatment(s)?</i>			
Other Tests: X-ray/MRI/CT Scan/Ultrasound/Surgery	Associated symptoms?		
<i>Notes:</i>			
LIFESTYLE: (0 best 10 worse)			
Diet: /10	Exercise: /week	Sleep: /10	Supplements: Y / N
Alcohol: /week	Coffee: /day	Smoke: sticks/week	Drugs: Y / N
<i>Notes:</i>			
FAMILY HISTORY			
Any of the Family might have? Heart Disease/Cholesterol/High Blood Pressure/Stroke/Diabetes/Cancer/Arthritis/Osteoporosis/Other:			
<i>Circle all symptoms that may apply to you present now and in the past:</i>			
Neuro-muscular:			
Headaches Migraine Tension Neck Pain Jaw Pain Spasms (where) Mid Back Pain Rib Pain Low Back Pain Scoliosis Hip Pain Sacrum Pain Knee Pain Ankle Pain Foot Pain Shoulder Pain Elbow Pain Wrist/Hand Pain Sprain/strain Tears Bursitis Fractures Bone Structure Irregularities Epilepsy Seizures Others:			
Eyes/Ears/Nose/Throat:			
Dizziness Blurred Vision Eye Pain/Strain Ringing in Ears Buzzing in Ears Sinusitis Swallowing Difficulty Sleep Apnoea Loss of Hearing Loss of Sight/ Smell/ Taste Light Sensitivity Other:			
Heart and Lung			
Chest Infections /congestions Heart Palpitations Chest Pain Shortness of Breath Irregular Heart Beat Heart Disease Hypertension Stroke Cold Limbs Hot Limbs Hypertension/ Hypotension Anaemia Asthma Bronchitis Other:			
Genitourinary Tract			
Back Pain during Menstruation Constipation Diaphorrea Pain on Excretion/Urination Abdominal Pain Stones of any kind _____ Digestion Difficulties Infections _____			
Metabolic, Allergies and Others			
Thyroid Conditions Seasonal Allergies Hormonal Conditions Depression Anxiety Panic Attacks Bleeding Gums Skin Conditions Nausea Nervousness Irritability Fatigue Loss of Balance Fainting Head Seems Heavy Loss of Memory Others:			