Absolute Health
Chiropractic & Physiotherapy

Mooloolaba Clinic
1/11 Walan Street
Mooloolaba, 4557
Ph: 07 5478 2333

Noosa Medical Centre
Suite 6, 1 Lanyana Way
Noosa Junction , 4567
Ph: 07 5478 2333

E: info@absolutechiropractic.com.au
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New patient intake form:

Welcome to Absolute Health Chiropractic & Physiotherapy. To enable us to assist you in reaching your health goals please take a few minutes to answer **all** the following questions as accurately as you can. Your answers will help determine how to best help you.

Patient details:

Full Name: _____ DOB: _____ Male ☐ Female ☐

Address: _____

Town: _____ Postcode _____

Phone: (M): _____ (H): _____ (W): _____

Occupation: _____ E-mail: _____

Status: Single ☐ Married ☐ Cohabitation ☐ Widow ☐

Partner's name: _____ Children & ages _____

Are you claiming part or full payment of care: No ☐ Yes ☐ If yes, please choose below

Private Insurance ☐ Insurer _____

DVA ☐ Workcover ☐ Medicare (EPC/CDM) ☐ Other _____ ☐

GP Name: _____ Medical Centre: _____

Permission to contact (if req) Yes ☐ No ☐

How did you find out about our clinic? _____

Is there any chance that you are pregnant: Yes ☐ No ☐

Health Questionnaire:

Reason attending clinic: Optimal health / prevention ☐

Specific Health concern ☐ (please fill in details below)

Reason for attending our clinic (if for a specific health concern):

_____

When did this problem start _____ **OR** Ongoing condition ☐

Please list any:

1. Previous surgery _____
2. Significant trauma / injury / accidents _____
3. Medications (within the previous 6 months) _____
4. Previous treatment (Chiro, Physio, other) _____
5. Significant illnesses or disability _____

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General health questionnaire:

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of your condition. Please tick the appropriate box if you have had any of the following symptoms in the past **12 months**. **Leave blank any that do not apply.**

Please tick (one box only) based on if the symptom occurs:
(O=Occasionally, F= Frequently, C=Constantly)

O	F	C	Head/Neck
☐	☐	☐	Headaches
☐	☐	☐	Light Headed
☐	☐	☐	Loss of Balance
☐	☐	☐	Hearing Loss
☐	☐	☐	Ringing in Ears
☐	☐	☐	Buzzing in Ears
☐	☐	☐	Neck Pain / Ache
☐	☐	☐	Grating / Cracking in neck

O	F	C	Shoulder, Arm, Fingers, Hands
☐	☐	☐	Pain
☐	☐	☐	Pins and Needles
☐	☐	☐	Numbness
☐	☐	☐	Weakness / Loss of strength
☐	☐	☐	Restricted movement
☐	☐	☐	Swollen Joints

O	F	C	Chest and abdomen
☐	☐	☐	Pain/ tightness in chest
☐	☐	☐	Pain around ribs
☐	☐	☐	Shortness of breath
☐	☐	☐	Wheezing
☐	☐	☐	Rapid heart beat
☐	☐	☐	Thumping Heart beat
☐	☐	☐	Stomach/Abdominal pain
☐	☐	☐	Belching or excessive wind
☐	☐	☐	Nausea
☐	☐	☐	Abdominal organ problems
☐	☐	☐	Constipation or diarrhoea
☐	☐	☐	Hernia
☐	☐	☐	Groin or pelvic pain

O	F	C	Low back, Legs or feet
☐	☐	☐	Pain
☐	☐	☐	Pins & needles
☐	☐	☐	Numbness
☐	☐	☐	Restriction of movement
☐	☐	☐	Swollen Joints

O	F	C	Geneto-Urinary System
☐	☐	☐	Urinary problems or infections
☐	☐	☐	Difficulty starting or stopping urination
☐	☐	☐	Loss of control or urination
☐	☐	☐	Bed wetting
☐	☐	☐	Prostate problems

O	F	C	Females Only
☐	☐	☐	Painful, tender or lumps in breasts
☐	☐	☐	Menstrual problems or abnormalities
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful intercourse

O	F	C	General symptoms
☐	☐	☐	Allergies, sinus problems ect.
☐	☐	☐	Excessive fatigue
☐	☐	☐	Chills, fever
☐	☐	☐	Fainting
☐	☐	☐	Sudden, recent loss of weight
☐	☐	☐	Depression or mental illness
☐	☐	☐	Excessive sweating
☐	☐	☐	Vascular disorders
☐	☐	☐	High blood pressure (hypertension)
☐	☐	☐	Low blood pressure

O	F	C	Neurological
☐	☐	☐	Tremors
☐	☐	☐	Loss of balance
☐	☐	☐	History of stroke, TIA, thrombosis ect.
☐	☐	☐	History of cardiovascular disease

Please tick if **yourself (S) or Family (F)** have had the following:

S	F	
☐	☐	Cancer
☐	☐	Vascular of heart disease
☐	☐	Arthritis or joint problems
☐	☐	Neurological conditions
☐	☐	Other serious illness
☐	☐	Diabetes
☐	☐	Other _____

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