

INITIAL CLINICAL QUESTIONNAIRE (CONFIDENTIAL)

NAME: Dr/Mr/Mrs/Ms/Miss _____

ADDRESS: _____

DATE OF BIRTH: _____ EMAIL: _____

MOBILE PH: _____ HOME PH: _____

OCCUPATION: _____ WORK PH: _____

WHO SHOULD WE CONTACT IN AN EMERGENCY? NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT THIS CLINIC? FAMILY / FRIEND / DOCTOR / SIGN / GOOGLE / OTHER

YOUR REGULAR DOCTORS NAME & CLINIC: _____

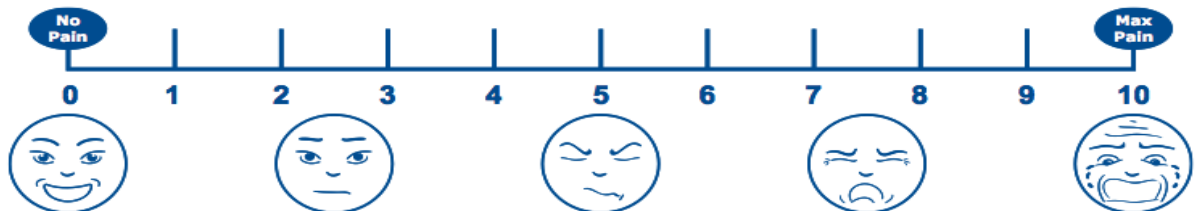
HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? YES / NO IF YES HOW LONG AGO? _____

Please complete the information on the following pages as accurately as possible, to enable us to help you.

YOUR COMPLAINTS - Please list your complaints in order of priority if more than one complaint.

COMPLAINT 1 (Describe) _____

Please use the chart to identify your level of pain or the level of severity of your problem

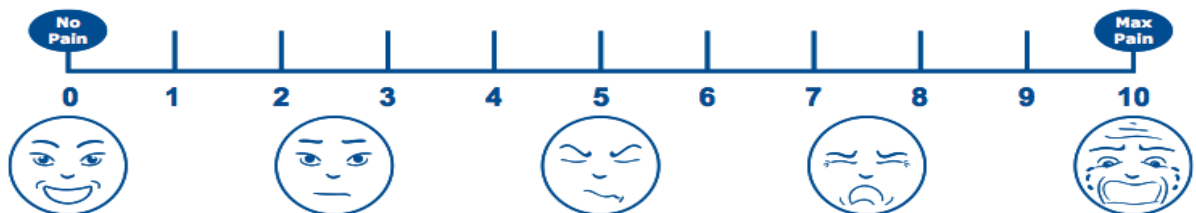


WHEN DID IT START? _____ WHAT CAUSED IT? _____

SINCE IT STARTED IS THE PROBLEM: GETTING BETTER / STAYING THE SAME / GETTING WORSE?

COMPLAINT 2 (Describe) _____

Please use the chart to identify your level of pain or the level of severity of your problem

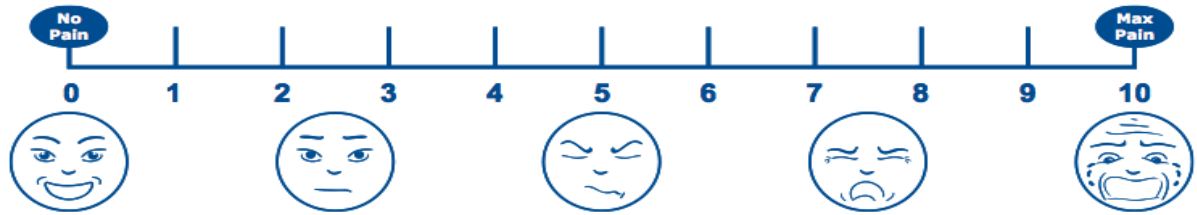


WHEN DID IT START? _____ WHAT CAUSED IT? _____

SINCE IT STARTED IS THE PROBLEM: GETTING BETTER / STAYING THE SAME / GETTING WORSE?

COMPLAINT 3 (Describe) _____

Please use the chart to identify your level of pain or the level of severity of your problem



WHEN DID IT START? _____ WHAT CAUSED IT? _____

SINCE IT STARTED IS THE PROBLEM: GETTING BETTER / STAYING THE SAME / GETTING WORSE?

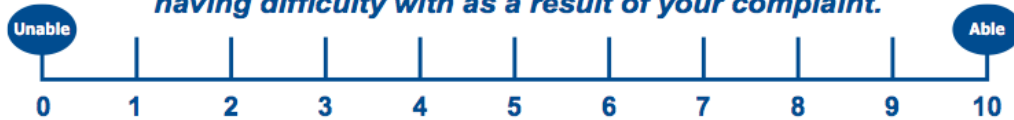
DOES ANYTHING MAKE YOUR SYMPTOMS BETTER? _____

DOES ANYTHING MAKE YOUR SYMPTOMS WORSE? _____

HAVE YOU HAD ANY OTHER TREATMENT FOR YOUR PROBLEM/S? NO / YES (PLEASE DESCRIBE TREATMENT)

USING THE SCALE BELOW - WHERE ZERO MEANS YOU ARE UNABLE TO COMPLETE THE TASK

Please identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your complaint.

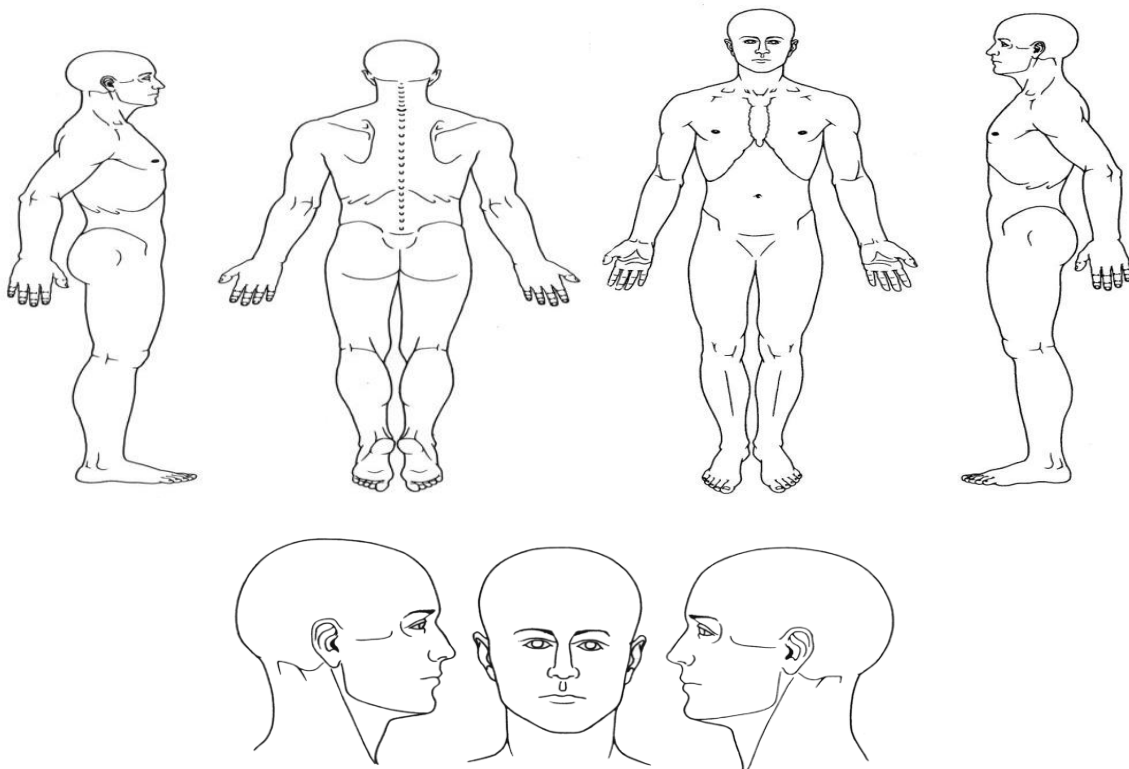


ACTIVITY 1: _____ SCORE OUT OF 10: _____

ACTIVITY 2: _____ SCORE OUT OF 10: _____

ACTIVITY 3: _____ SCORE OUT OF 10: _____

WHERE IS THE PROBLEM? Please mark on the diagrams below where the areas of concern are



MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICATIONS: _____

PLEASE LIST ALL PREVIOUS SURGICAL OPERATIONS: _____

HAVE YOU HAD ANY BROKEN BONES? NO / YES - please list which bone and when _____

HAVE YOU EVER HAD ANY FORM OF CANCER? NO / YES - please describe type and when _____

HAVE YOU EVER HAD ANY FORM OF SPINAL INJURY OR WHIPLASH? NO / YES please describe type and when _____

ARE YOU/OR COULD YOU BE **PREGNANT**? _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH? _____

AUTHORISATION

I confirm that I am not under the influence of alcohol, illicit drugs, or any other substance that may impair my judgement, or affect my ability to understand and sign this authorisation.

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 services rendered are due at the time of service and cannot be deferred to a later date.

Patients Signature _____ Date __ / __ / __ Witness _____

It is a standard practice of this clinic to correspond with your medical practitioner, coach or personal trainer if and where appropriate.

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner, coach or Personal Trainer.

Patient Signature _____ Print Name _____ Date _____

Gonnet Chiropractic provides an appointment reminder service by SMS and may also communicate with you from time to time by email or SMS. 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 communicate by SMS and email