Your ALLIED HEALTH CENTRE
chiropractic • acupuncture • massage • physiotherapy

Shop 9, Woolworths Marketplace
Cnr Old Northern Road &
Albany Forest Drive
Albany Creek
Q 4035

phone: 07 3325 0506
email: care@yahc.com.au
web site: www.yahc.com.au

Patient Case History : All information contained in this questionnaire is strictly confidential

Full Name:				**DOB:**
Address:				
Postal Address:				
Phone: (H)		**(W)**		**(M)**
Email Address:				
Occupation:				
Next of Kin Name:			**Contact Number:**	
Seeking	Chiropractor	Physiotherapist	Acupuncturist	Massage Therapist
Case practitioner:				

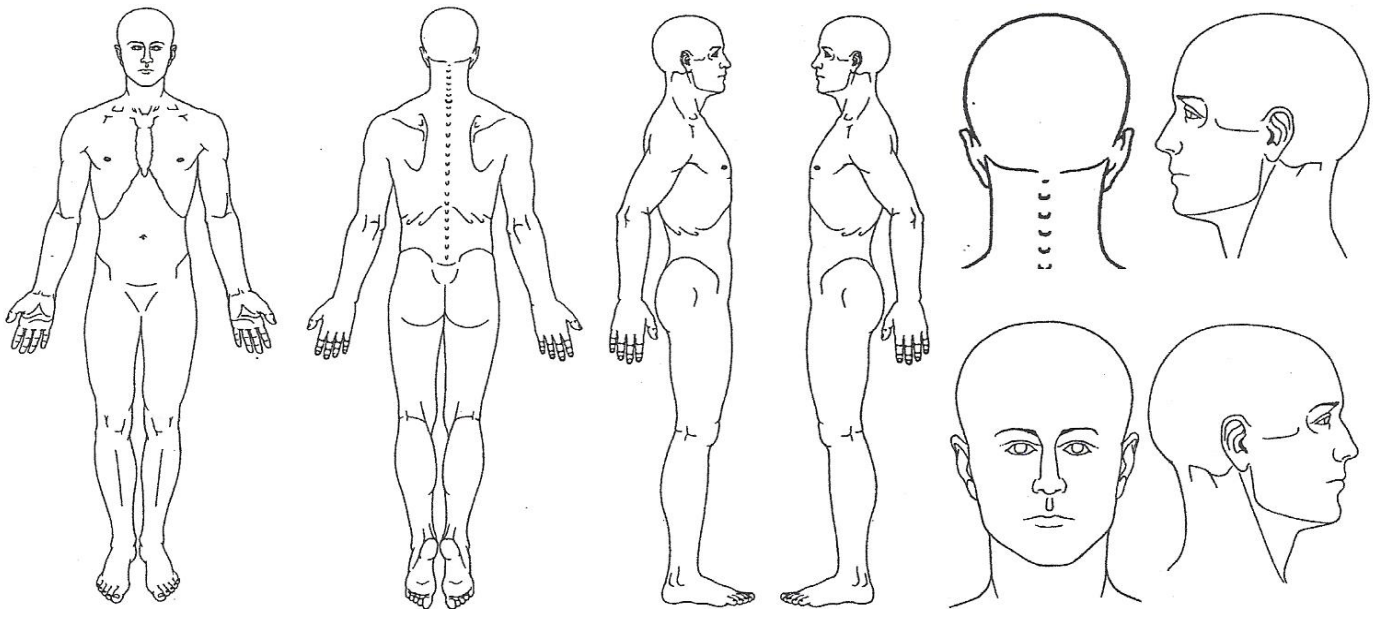
Your Health Profile

Addressing the issues that brought you to this practice

Please describe the main area/s of your complaint:

If you are experiencing discomfort, is it?		Sharp	Dull	Pins and Needles
		Numbness	Constant	Comes and Goes
Since problem started, is it?		About the same	Getting worse	Getting better
It interferes with:		Work	Leisure	Sleep
		Sports	Other:	
Currently your symptoms are aggravated by:		Bending	Reaching	Lifting
		Sitting	Standing	Walking
		Straining at stool	Coughing/Sneezing	Neck movement
		Other:		
Pain Scale	Primary: Condition	No pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10		Excruciating pain
	Secondary: Condition	No pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10		Excruciating pain

Please indicate location and sensation of your body pain



Your Medical History

Help us gain a greater understading and approach your treatment holistically

Did you participate in aggressive youth sports?	Yes	No	What/When?
Did you have any Childhood illnesses?	Yes	No	What/When?
Did you have any serious falls/injuries?	Yes	No	What/When?
Did you had any serious health problems?	Yes	No	What/When?
Have you been in any motor vehicle accidents?	Yes	No	What/When?
Have you had any surgery or been in hospital?	Yes	No	What/When?
Have you fractured or broken any bones?	Yes	No	What/When?

Please circle all symptoms you have ***ever*** had, even if they do not seem related to your current problem

Neck stiffness	Headache	Migraine	Nausea/vomiting	Indigestion
Loss of balance	Dizziness/fainting	Fatigue	Depression	Blurred vision
Bowel/Bladder issue	Chest discomfort	Back discomfort	Numbness in fingers	Numbness in toes
Sound sensitivity	Light sensitivity	Pins and Needles in arms	Pins and Needles in legs	
High Blood Pressure	Low Blood Pressure	Infectious Disease	Diabetes	Stroke

Your Medical Doctors Name:	Contact Details:

Please list all current diagnosed medical conditions and prescription medications

Family Medical History

Please mention below any health conditions or concerns your family may have

Mother	
Father	
Siblings	
Children	

Lifestyle Profile

What do you want to gain from our practice?	
What are your ultimate health goals/desire outcomes?	
What is your passion in life? Hobbies/Special interests	

Do you wish for your case practitioner to discuss your condition with other health care practitioners from this centre?

Chiropractor	Physiotherapist	Acupucturist	Massage therapist

Who may we thank for referring you to our Practice?	☐ Internet ☐ Signage ☐ Word of mouth – Person's Name:

For Women

Are you pregnant?	Yes	No	Unsure	Date last menstrual cycle:

Please Read And Sign

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examnine me for further evaluation.

Patient's/Guardian's Signature: Date: