CLIENT HEALTH HISTORY

Client Name: _____ Date: _____

People consult our Chiropractic Centre with varied health objectives. Please indicate the main reason/s you are seeking chiropractic care at our centre:

- Relief of symptoms
- Correction of my underlying problem
- Better perform work or recreational activities
- Improve my health and enhance my quality of life

Can you provide us with some specific details about your reason for seeking care today?

_____
_____
_____
_____

Is your appointment today because of a recent accident or injury? Yes / No

Do you have an existing health care team helping you to manage your health?

_____
_____
_____

Do you have any existing health problems? If yes, please list:

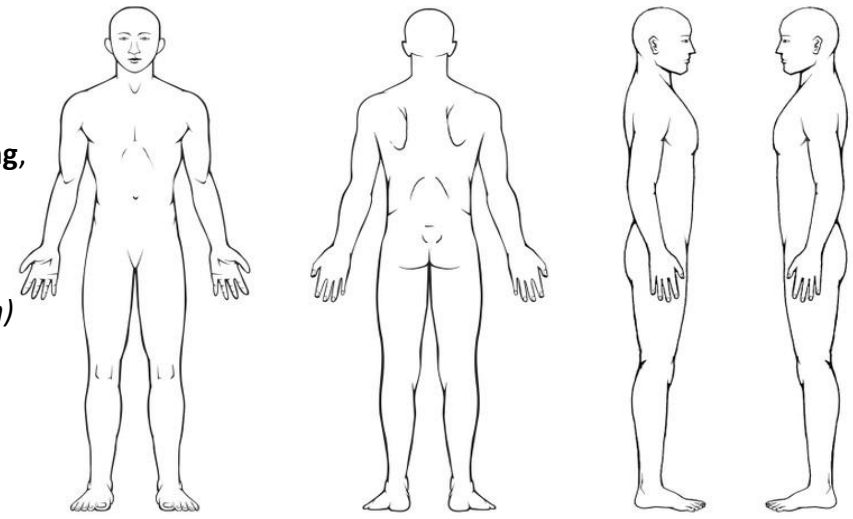
_____
_____
_____

Please share with us if there are certain activities you would like assistance improving or health goals you would love to achieve:

_____
_____
_____

If you experience **pain, numbness, or tingling**, please mark the areas on diagrams with:

P for pain and give it a mark from 1 – 10
(1 being slight and 10 being unbearable pain)
N for numbness and
T for tingling



FRONT BACK RIGHT LEFT

CLIENT HEALTH HISTORY

Client Name: _____ Date: _____

Please circle each individual answer and provide additional information when indicated. Include both ***past*** and ***present*** conditions.

Please return the completed form to the front desk when completed.

Client's Current General History

001: **Y** **N** Recent weight change ↑ or ↓
002: **Y** **N** On-going fever / chills
003: **Y** **N** Periodic unexplained sweats
004: **Y** **N** Re-occurring allergies
005: **Y** **N** Anaemia
006: **Y** **N** Bleeding / bruising
007: **Y** **N** Malaise / fatigue / weakness
008: **Y** **N** Immuno-deficient condition
009: **Y** **N** Cancer: _____
_____

Lifestyle

010: **Y** **N** Do you eat a healthy diet?
011: **Y** **N** Have an unusual appetite?
❑ large ❑ small
012: **Y** **N** Consume caffeine?
Frequency _____/day or week
013: **Y** **N** Consume alcohol?
Frequency _____/day or week
014: **Y** **N** Consume water?
Frequency _____/day
015: **Y** **N** Eat junk food frequently?
Frequency _____ /day or week
016: **Y** **N** Exercise / sports activity
Frequency _____ /day or week
017: **Y** **N** Smoker? past / present
018: **Y** **N** Hobbies: _____
019: **Y** **N** Work stress
020: **Y** **N** Home stress
021: **Y** **N** Always busy
022: **Y** **N** Poor sleep
023: **Y** **N** Relationship stress

Musculoskeletal System

024: **Y** **N** Joint stiffness / pain / swelling
025: **Y** **N** Muscle cramps
026: **Y** **N** Neck pain
027: **Y** **N** Upper back pain / mid back pain
028: **Y** **N** Low back pain
029: **Y** **N** Buttock / groin pain

Musculoskeletal System Continued

030: **Y** **N** Upper limb condition
031: **Y** **N** Lower limb condition
032: **Y** **N** Fractures / dislocation / sprains
033: **Y** **N** Other injuries – include auto accidents, sports injuries and work-related accidents
034: **Y** **N** Other musculoskeletal conditions:
Type: _____
_____

Neurological System

035: **Y** **N** Headaches
036: **Y** **N** Seizures / epilepsy / involuntary twitches
037: **Y** **N** Dizziness / fainting
038: **Y** **N** Numbness / tingling
039: **Y** **N** Limb weakness
040: **Y** **N** Head trauma / concussion
041: **Y** **N** Stroke
042: **Y** **N** Disc injury
043: **Y** **N** Other neurological conditions
_____
_____

Family History

044: **Y** **N** High blood pressure
045: **Y** **N** Heart disease, type: _____
046: **Y** **N** Stroke
047: **Y** **N** Cancer, type: _____
048: **Y** **N** Musculoskeletal disease,
type:_____
049: **Y** **N** Other family illness history:
_____
_____
_____
_____

Endocrine History

050: **Y** **N** Heat / cold intolerance
051: **Y** **N** Thyroid conditions
052: **Y** **N** Diabetes

CLIENT HEALTH HISTORY

Australian Chiropractic College

Client Name: _____ Date: _____

Eye / Ear / Nose / Throat

053: **Y** **N** Corrective lenses
054: **Y** **N** Eye redness, swelling, tearing, pain or itching
055: **Y** **N** Other visual conditions
056: **Y** **N** Difficulty hearing / deafness / ringing in ears
057: **Y** **N** Ear growths / discharge / pain
058: **Y** **N** Change in ability to smell or taste
059: **Y** **N** Nose growths / discharge / bleeding / pain
060: **Y** **N** Sinus conditions
061: **Y** **N** Hoarseness
062: **Y** **N** Difficulty chewing or swallowing
063: **Y** **N** Enlarged / painful glands
064: **Y** **N** Growths / lesions in mouth or throat

Gastrointestinal System

065: **Y** **N** Change in appetite
066: **Y** **N** Food intolerance
067: **Y** **N** Nausea / vomiting
068: **Y** **N** Indigestion/heartburn/excessive belching/gas
069: **Y** **N** Abdominal pain or swelling
070: **Y** **N** Change in bowel habits or stool (colour, consistency etc.)
071: **Y** **N** Hernia
072: **Y** **N** Haemorrhoids
073: **Y** **N** Gallbladder / liver / pancreas disease
074: **Y** **N** Liver disease

Respiratory System

075: **Y** **N** Difficulty breathing / wheezing / asthma
076: **Y** **N** Coughing / sneezing
077: **Y** **N** Tuberculosis / TB exposure
Date: _____
078: **Y** **N** Respiratory infections: COVID, pneumonia, etc
079: **Y** **N** Exposure to dangerous fumes, toxic chemicals, or excessive pollution
Date & type: _____

Cardiovascular System

080: **Y** **N** Chest discomfort / pain
081: **Y** **N** Palpitations
082: **Y** **N** Swelling / oedema
083: **Y** **N** Cold hand / feet
084: **Y** **N** Fainting
085: **Y** **N** High blood pressure
086: **Y** **N** Heart disease (past / current)
087: **Y** **N** Rheumatic fever

Urinary System

088: **Y** **N** Frequent urination
089: **Y** **N** Increased thirst
090: **Y** **N** Urinary urgency / pain / hesitancy / discharge / dribbling
091: **Y** **N** Urinary tract infections
092: **Y** **N** Kidney disease / stones
093: **Y** **N** Flank (side) / pelvic pain

Skin / Hair / Nails

094: **Y** **N** Change in skin texture / colouration
095: **Y** **N** Mole changes
096: **Y** **N** Change in hair / finger or toe nails

Breasts (Male and Female)

097: **Y** **N** Breast lumps / mass / growths / pain / tenderness / dimples
098: **Y** **N** Nipple discharge / bleeding

Reproductive System

Sex at birth: _____

(Male only)

099: **Y** **N** Erectile dysfunction

(Female only)

100: **Y** **N** Heavy / painful / irregular periods
101: **Y** **N** Menopause
102: **Y** **N** Diagnosed reproductive conditions
103: **Y** **N** Are you currently pregnant?
104: **Y** **N** Fertility issues

Hospital / Surgery / Medications

105: **Y** **N** Implants / supports (including heel lifts)
106: **Y** **N** Cardiac (pacemaker, etc.)
107: **Y** **N** Have you had any other hospitalisation or surgery?
108: **Y** **N** Current prescribed medications

Medication Reason

_____
_____

109: **Y** **N** Non-prescribed medications or drugs (including over-the-counter or recreational)

Medication Reason

_____
_____
_____

CLIENT HEALTH HISTORY

Client Name: _____ Date: _____

Psychological History

110: Y N Anxiety

111: Y N Depression

112: Y N Hospitalization for psychological care

113: Y N Other psychological conditions:

_____

114: Over the last 2 weeks how often have you been bothered by the following problems:

114.1 Feeling nervous, anxious or on edge

❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

114.2 Not being able to stop or control worrying

❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

114.3 Little interest or pleasure in doing things

❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

114.4 Feeling down, depressed, or hopeless

❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

Other

115: Y N Is there anything else you think we need to know about you?

_____

_____

_____

I have reviewed and certify that all the information that I have reported above, is true to the best of my knowledge.

_____

Client Signature Date

HISTORY REVIEW

Intern Name: _____

_____

Intern Signature Date

Chiropractic Mentor Name: _____

_____

Chiropractic Mentor Signature Date

FOR INTERNS USE ONLY *Most pertinent DDX's (H: hallmark, E: exam to R/I or R/O)*
1:
H:
E:
2:
H:
E:
3:
H:
E:
4:
H:
E:
5:
H:
E:
6:
H:
E:
7
H:
E:
8:
H:
E: