# things we need to know about you

**First name:** **Last name:**

**Preferred name:** **DOB:** / /

**Phone:** Mobile Home

**Email:**

**Address:**

Town State Postcode

**Occupation:**

**Referred by:**

**Emergency contact:** First name & last name of person to contact in an emergency

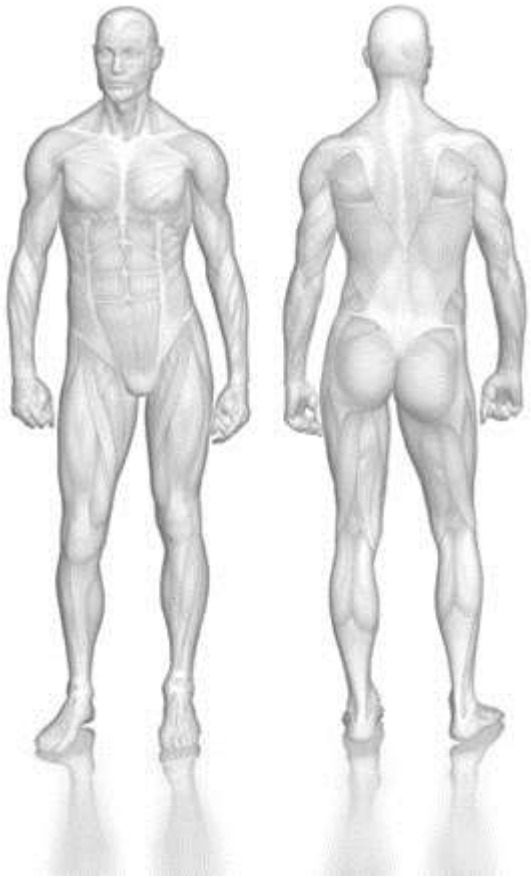
**Emergency phone:** **Emergency relationship:**

**Name of your usual GP:**

**How did you find out about Dr. Greg?**

**Main reason for seeking chiropractic care:**

**If your main reason is a symptom (e.g. pain, tingling, numbness), circle area(s) on the illustration:**



**When did this begin?**

**How did this begin?**

**Describe the symptom (e.g. dull, sharp, burning):**

**Rate the current symptom intensity on this scale:**

*(0 = no symptom and 10 = worst possible symptom)*

**0 1 2 3 4 5 6 7 8 9 10**

**How frequent is the symptom present and how long does it last? Is it getting better or getting worse?**

**Does anything make it feel worse?**

**Does anything make it feel better?**

**Have you had any previous treatment for this problem?**

**In terms of your general health, do you have (or have you had) any health/medical problems?**

**List any medications (and reason why) that you have taken within the past 12 months:**

**List any major surgeries and year (or your age) when performed:**

**List all body trauma/injuries (including broken bones, car accidents, falls, work injuries, birth trauma, sporting injuries, head impact, etc.) you have experienced and when they occurred:**

**Have you had any diagnostic testing (including x-rays, MRI, CT or blood tests)? If yes, when?**

**Briefly describe your exercise routine:**

**Briefly describe your sleep routine (including quality and average number of hours):**

**Briefly describe any significant stress in your life (i.e. home; work; money; health; family; etc):**

**Are you a smoker? If yes, briefly describe your usual daily habit:**

**Have you been to a chiropractor before? If yes, briefly describe when and why:**

**Tick any of the following symptoms you've ever had:**

☐ Arthritis ☐ Back curvature ☐ Mental/emotional disorders ☐ Swollen or painful joints

☐ Skin problems ☐ Bruise easily ☐ Headache ☐ Migraine headache ☐ Neck pain ☐ Shoulder pain

☐ Numbness or tingling ☐ Carpal tunnel syndrome ☐ Dizziness ☐ Asthma ☐ Chest pain

☐ Difficulty breathing ☐ Heart problems ☐ Heart attack ☐ Low blood pressure

☐ High blood pressure ☐ Cancer ☐ Allergies ☐ Frequent colds ☐ Upper back pain

☐ Blurred vision ☐ Constipation ☐ Diarrhea ☐ Impotence ☐ Kidney problems

☐ Menstrual problems ☐ Menopausal issues ☐ Epilepsy/convulsions ☐ Ringing in ears

☐ Hearing loss ☐ Loss of balance ☐ Digestive problems ☐ Depression ☐ ADD/ADHD

☐ Anxiety disorder ☐ Eating disorder ☐ Difficulty concentrating ☐ Loss of memory ☐ Ear infection

☐ Learning disability ☐ Prostate issues ☐ Varicose veins ☐ Liver issues ☐ Gall bladder issues

☐ Mid back pain ☐ Sciatica ☐ Stroke ☐ Muscle tightness ☐ Trouble sleeping ☐ Thyroid issues

☐ Adrenal issues ☐ Pins and needles ☐ Poor circulation ☐ Apnoea ☐ Fatigue

**The information I have provided is true and correct and I agree to disclose any information that may assist the Chiropractor to better understand my case:**

**Sign:** Please sign your name **Name:** Please print your name

**Date:** / /

DR. GREG KENDALL

*Ver. 3.3*

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