Longbeach Chiropractic & Wellness Centre

9 Carlton Close, Noordhoek, Longbeach Business Village

PATIENT'S INFORMATION FORM

021 785 4855

Full name: _____ Referred by: _____

Today's date: _____ Occupation: _____ Birth date: _____

Home Address: _____

_____ Postal Code: _____

Postal Address: *(if different than above)* : _____

Tel: (H) _____ (W) _____ Cell Phone: _____

Email address: _____

Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed ☐ Children ☐

Medical Aid: _____ Doctor: _____

MEDICAL DETAILS (PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE)

Presenting Complaint: _____

How & when did it occur? _____

Has this occurred before? When? _____

Is there a time of day that the pain is worse? AM: Yes ☐ No ☐ PM: Yes ☐ No ☐

On a scale of 0 to10, how bad is your pain? _____

What impact have your symptoms had on your life? _____

What previous treatment have you had for this condition (Physio, Chiropractic, Medical etc.)? _____

What makes the pain better or worse? Better: _____ Worse: _____

Rate your stress levels (circle one) NO STRESS 0 1 2 3 4 5 6 7 8 9 10 VERY STRESSED

List any prior serious injuries: _____

List fractures/ broken bones: _____

List serious illnesses: _____

List surgeries and dates: _____

List present medication: _____

What type of exercise do you do? : _____

Have you ever had a car/motorcycle accident? (If yes, list approx dates) _____

Have you ever had X-rays/scans? (If yes, list approx dates) _____

What major disease(s) run in your family (heart attack, cancer etc.)? _____

Have you ever had your bone density checked? _____

PLEASE READ CAREFULLY BEFORE SIGNING BELOW

- I have read all the above thoroughly. I hereby give permission to Longbeach Chiropractic for treatment.
- I acknowledge that a 24 hour notice is required before cancellation or change of any appointment that I may make in the future.
- I acknowledge that full payment is expected at time of each treatment unless an agreement has been made otherwise.

SIGNED: _____ DATE: _____