DRAGONFLY
WELLNESS

Patient Case History

All information contained in this form is strictly confidential.

Full Name: ______________________ **Date of Birth:** __________

Sex: Male Female

Address: ______________________

Phone (M): __________ **Phone (H):** __________ **Phone (W):** __________

Email: ______________________

Occupation: __________ **Concession card?** **Expiry?** __________

Next of Kin: __________ **Contact number:** __________

Are you a member of a health fund? **Which fund** __________

Who may we thank for referring you to our practice? friend family internet other

Name of friend or family member: __________

Current Complaints

Area of Chief Complaint:

When did this begin: ______________________

Describe your pain? Sharp Dull Ache Burning Throbbing Deep Shooting

Frequency of your chief complaint: Constant Intermittent Occasional Rare

Since the problem started, is it? About the same Getting better Getting worse

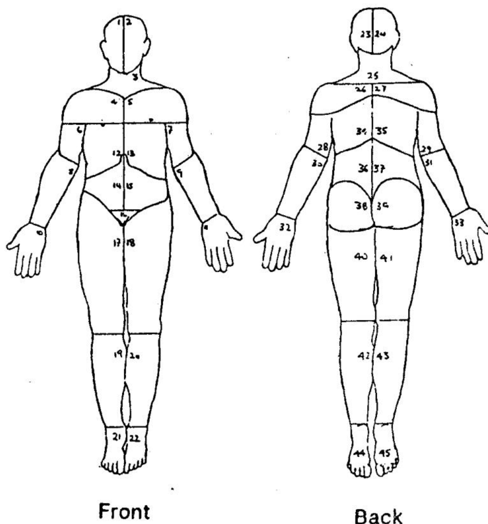
It interferes with: Work Sleep Hobbies Leisure Home activities other

Additional Complaints (Please describe):

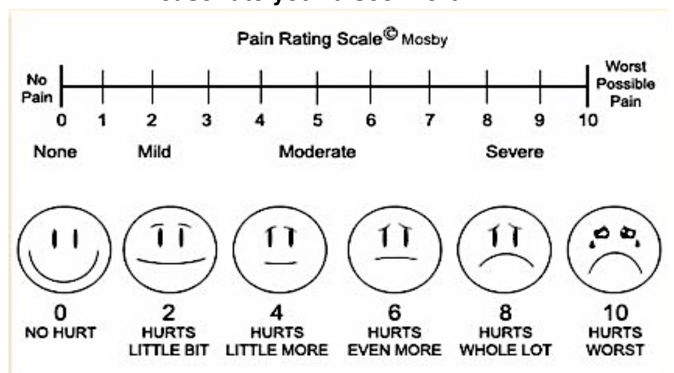
Please tick all symptoms you have had, even if they do not seem related to your current problem:

Back Discomfort	Pins and Needles	Constipation/Diarrhea
Neck Discomfort	Radiation of Pain	Bowel or bladder problems
Headaches	Dizziness/Fainting	Depression
Blurred Vision	Fatigue	Chest Discomfort
Numbness	Loss of Balance	Asthma
Tingling	Indigestion	Loss of smell/taste

Please circle your problem areas:



Please rate your discomfort:



Currently, what makes your symptoms worse: ______________________________

Does anything relieve your symptoms: ______________________________

Previous treatments or medication for this complaint: ______________________________

____

Have you seen a chiropractor before? Name of Chiropractor: ______________

Location: ______________________________ Date of last adjustment: __________

What were the results of your care: excellent satisfactory fair did not help worsened

Did the Chiropractor take x-rays? Did you have a thorough examination?

Health History

(If you need more space for your information, please attach a seperate page)

Birth to age 17

Do any of the following apply to you:

- Participate in aggressive youth sports? (describe): ______________
- Childhood illnesses? (describe): ______________
- Serious falls/injuries as a child (describe): ______________

____

- Surgery or hospitalizations as a child (describe): ______________

____

Adult (18 years to present)

Please list any serious health problems, accidents or falls:

Regarding your health:

- Have you had surgery/been in hospital? (describe): ______________

____

- Have you had any broken bones? (describe): ______________

____

- Do you have a lot of stress? (on a scale of 1 - 10): ______________
- How would you describe your overall health? (describe): ______________

____

- Any medications or supplements? (describe): ______________

____

- Do you have any allergies (describe): ______________
- Name and address of medical doctor: (Name) ______________
- (Address) ______________________________

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For Women: Are you pregnant (Date of last period): ______________

(any womanly concerns?): ______________________________

Family Health Profile

At our office we are not only interested in your health and well-being, but also that of your family and loved ones. Please mention any health conditions of concern you may have about your:

Mother: ______________ Father: ______________

Spouse: ______________ Children: ______________

Friends: ______________

Lifestyle Profile

What do you want to gain from chiropractic care? ______________________________

What are your ultimate health goals? ______________________________

What is your passion in life? Hobbies/Interests: ______________________________

PLEASE READ AND SIGN (In the presence of the Chiropractor):

I have read the above information and certify the statements made are true and correct to the best of my knowledge and I agree to allow this office to examine me for further evaluation, to refer me out for x-rays, if required, and to provide me with chiropractic care.

Patient's/Guardian's Signature:______________________________Date: __________