Dr Justin Portelli D.C.

HEALTH QUESTIONNAIRE- Chiropractic

Name:____

Address:____

Date of birth:_______________________ Occupation:_________________________

Phone:_____________________________Moblie:_____________________________

Email:_____________________________________

Are you a member of a health fund: YES / NO Name of fund:___________________

How did you hear about us: □ News paper, □Yellow pages, □ Sign,

□Friend name______________, other_______________

What is the main reason for today's visit:_____________________________________

____

Is this a work injury? □ yes □no Were you injured in a transport accident? □yes □no

Have you had and treatment for this problem? □yes □no

HEALTH CHECKLIST (Tick the following if they are currently affecting you)

Headaches		Poor Concentration		High Cholesterol		Constipation/Diarrhoea	
Indigestion		Dizziness		Ear Noises		Rapid weight loss	
Low Energy		Blurry Vision		Asthma		Fevers	
Difficulty breathing		High blood pressure		Diabetes		Pain that wakes at night	

Have you had any major surgery? □ yes_______________ □no

Have you had any major accidents? □ yes______________ □ no

Are you currently taking and DRUGS OR MEDICATIONS (please list)

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I understand that payment is due at time of consultation. Generally, Chiropractic is a very safe and gentle form of treatment. However, there are risks from treatment to the neck and back. Although very rare, stroke may occur if there is injury to the neck artery following neck adjustment. Disc injury is also possible following neck and back adjustment. Please discuss this with your Chiropractor.

Signature___________________________________ Date____________________________

Thank you for taking the time to fill in this questionnaire, it will greatly assist with the consultation process.