# Avia Chiropractic Intake and History

## Patient Information

Last Name: First Name:

Home Address: Suburb: State:

Mobile Number: Home Phone:

Email:

Date of Birth: Medicare? ◯ Y ◯ N

How many children do you have? What are their ages?

Occupation/Student: Employer/School:

General Practitioner Name: GP Phone Number:

How did you hear about us? Google ◯ Social media ◯ Referral ◯ Walking past ◯

If referred, who can we thank for referring?

## Emergency Contact

First Name: Relationship:

Contact Number:

## Pregnancy

Are you currently pregnant? ◯ Y ◯ N If Yes, when are you due?

No. of past pregnancies: Any health concerns regarding this pregnancy?

## Health and Illness History

Please tick the circle beside any condition that you have or have had

- ◯ Arthritis
- ◯ Asthma / Allergies
- ◯ Cardiovascular Issues
- ◯ Cancer
- ◯ Circulation Issues
- ◯ Childhood Illness
- ◯ Diabetes
- ◯ Digestive Issues
- ◯ Headaches / Migraines
- ◯ Heart Disease
- ◯ Hepatitis
- ◯ Immune Issues
- ◯ Scoliosis
- ◯ Stroke
- ◯ Urinary Issues
- ◯ Osteoporosis

◯ Medical devices and implanted devices such as intra-cranial aneurysm, clips, cardiac pacemaker, coronary stents, intra ocular foreign bodies and cochlear implants (circle relevant)

## Allergies, Medications and Supplements

| Allergies (Please List) | Medications (Please List) | Supplements (Please List) |
|---|---|---|
| | | |
| | | |
| | | |

## How can we help you?

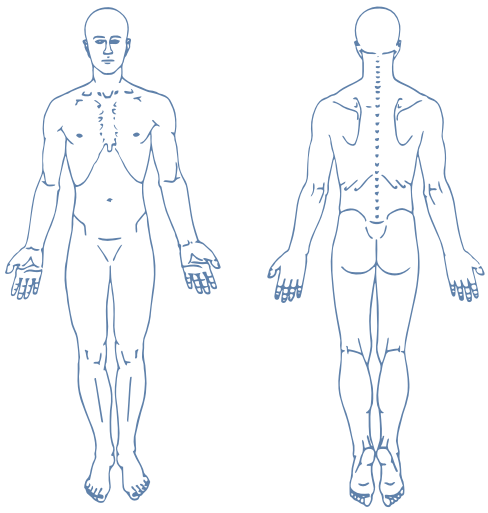
What brings you in today?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| How long have you been noticing pain/stiffness? | Years: | | | Months: | | | | Days: | | | |
| Please rank your pain/stiffness out of 10: (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| During the week, how many days is it present? (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Constant | | |
| Each day how many times does it occur: (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Constant | |
| Out of 10 rate your stress levels: (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Out of 10 – 10 being a great sleep, rate your sleep: (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please place a cross (X) on the diagram below where you are experiencing your pain/stiffness:

What do the symptoms feel like?

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramping
- ○ Nagging
- ○ Sharp
- ○ Shooting
- ○ Burning
- ○ Throbbing
- ○ Stabbing
- ○ Swelling
- ○ Other: _____



## Impact of Your Symptoms

How are the symptoms/condition interfering with your life? Check circle where appropriate.

| | No effect | Mildly | Fairly | Severely | | No effect | Mildly | Fairly | Severely |
|---|---|---|---|---|---|---|---|---|---|
| Work | ○ | ○ | ○ | ○ | Mood | ○ | ○ | ○ | ○ |
| Exercise | ○ | ○ | ○ | ○ | Productivity | ○ | ○ | ○ | ○ |
| Downtime | ○ | ○ | ○ | ○ | Energy | ○ | ○ | ○ | ○ |

Patient Signature: Date: