



st.kildaroadchiropractic

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New Patient Questionnaire

Your Details

Name Dr/Mr/Mrs/Ms/Mstr Date of Birth.....

Address:.....

Phone: (H).....(W)(M).....Occupation.....

email:Your Employer.....

How did you find out about us ? (please circle appropriate answer and write details)

Recommended by a ; Friend / Work colleague / Health Practitioner: (Their Name).....

Internet Search/ Yellow Pages / Advertising / Signage/ Your Health Fund

Other :

Your Spinal Health

What would you like to discuss with your Chiropractor today?.....

Has this problem occurred before? If so, when, and who did you see about it?.....

Did your problem result from a motor vehicle or in the workplace accident? No/Yes

Does this problem restrict you in performing your work , recreational or daily duties No/ Yes (In what way?)

Have you previously had X-rays or other tests done for this injury? No/Yes

Your General Health

Have you had a major illness , trauma or stay in hospital in the past? No/Yes

Is there a history of major illness in your family ie. Cancer, Diabetes, Heart disease? No/Yes

Please list details of any medications or supplements that you are currently taking

Are you, or were you a smoker? No/ Yes (How many for how long?).....

Do you suffer from dizziness, nausea, weakness, visual disturbances, numbness/tingling in the arms or legs No/ Yes

Have you previously had a rib fracture? No/Yes.....

Do you exercise No/Yes (What and how much?)

Office Use Only: DATE :

File#:

HA/ CSP/ CB/ T/ L/ Pel/ Ext / Visc/ Pos /Well /