Entrance Form - Dr. Jean-Jacques Lob, chiropractor

Surname: ____________________________ Name: ___________________________
Preferred name: ____________________________
eMail: _____________________________________
DOB: ___________________ Age: _____
Home address: ____
Suburb: _____________________________ Post code: _______
Phone (home): __________________ Mobile: ___________________
Occupation: __________________________________
Emergency contact number: ____________________
Emergency contact relationship to you: ____________________
How did you find about us? ____
What is the reason for seeking our help? _____________________________________
____
If having pain or other symptoms, when did they start? ________________________
Have you had previous episodes of this problem? _____________________________
What brings on your eventual condtion and makes it worse? ____________________
____
Do you suffer from dizziness or vertigo? ___
Any work or vehicular related injury? ___
If yes, please give details ____
Any other injury? ____
What sports do you play, if any? ____
Any surgery of any kind? ____
Please provide a brief history: ____
Do you smoke? __ Any type of medication: ________________________________
Apart from main complaint, any other health concern? _________________________
if so, please describe ____
Any of the following symptoms during the last thirty days:
Pain worse at night: _ Lose of bowel/bladder _ Constant pain _
Bacterial/Viral infection _ Fever _ Unexplained weight loss _
Please select if you have had any of the following:
Blood transfusion _ History of cancer _ HIV _ Steroids _
Have you been hospitalised? _ dates and reason:______________________________
____
____
Had chiropractic care? _ when? _____ Name of chiropractor ____________________
Had medical care? _ Name of physician _____________________________________
Notes: ____
____
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____

Return completed form prior to appointment time to: chirolob@yahoo.com