PINCEPT
A New Health Dimension
• Specialized Spinal Rehabilitation
• Posture Correction
• Sports Injuries
• Family Wellness Care
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Name: _____ Age: _____ Date: _____

Address: _____Post Code_____

Home Telephone: _____ Mobile: _____

Occupation: _____ Date of Birth: _____

Reason/s for consulting our office?

_____

Who may we Thank for referring you to our office? _____

Health Fund / Private Insurance _____

*** Your Childhood Years**

Did you have any serious falls as a child? _____

*** Adult**

Have you been in any accident/trauma in the past? _____

Have you had any surgery? _____

*** If you are experiencing pain, is it**

 Sharp Dull Comes & Goes Travels Constant

*** Please check ( ) symptoms you currently have, even if they do not seem related to your current problem.**

( ) headaches	( ) Pins & Needles in legs	( ) Fainting	( ) Neck Pain
( ) Pins & Needles in arms	( ) Loss of smell	( ) Back Pain	( ) Loss of Balance
( ) Dizziness	( ) Buzzing in ears	( ) Ringing in ears	( ) Nervousness
( ) Numbness in fingers	( ) Numbness in toes	( ) Loss of taste	( ) Stomach Upset
( ) Fatigue	( ) Depression	( ) Irritability	( ) Tension
( ) Sleeping problems	( ) Neck stiff	( ) Cold Hands	( ) Cold feet
( ) Diarrheal	( ) Constipation	( ) Fever	( ) Hot Flashes
( ) Cold Sweats	( ) Lights bother eyes	( ) Problem Urinating	( ) Heartburn
( ) Mood swings	( ) Menstrual Pain	( ) Menstrual Irregularity	( ) Ulcers

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature _____ **Date** _____