



# DR. VICTOR J. PORTELLI

**Chiropractors:** Dr Victor Portelli, Dr Anthony Papaluca, Dr. Bojan Peric  
Applied Kinesiology & Organ Biomechanics - Acupuncture/ Hypnotherapy. Romaine Sundaram -Naturopath

## HEALTH QUESTIONNAIRE



Name: Dr/ Mr/Mrs/Miss/ \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (M) \_\_\_\_\_ (Bus) \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_ No. of children \_\_\_\_\_

(Please let us know if you don't want to receive emails of our updates or workshops)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_



**Are you a member of a private health fund? YES/ NO** Name: \_\_\_\_\_

**How did you hear about us:** Newspaper/ Sign/Friend/Dr./ Other (name) \_\_\_\_\_

**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**

**Has anyone treated you for this problem? YES/ NO**

**What was the type of the treatment?** \_\_\_\_\_

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



Headaches	<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Constipation/ Diarrhoea	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	Dizziness/blurriness	<input type="checkbox"/>	Ear Noises	<input type="checkbox"/>	Rapid weight loss	<input type="checkbox"/>
Low energy	<input type="checkbox"/>	Blood disorders	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Fevers	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Painful Menstruation periods	<input type="checkbox"/>
Infections	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	Allergies	<input type="checkbox"/>		<input type="checkbox"/>

Have you had any surgery? YES/ NO \_\_\_\_\_ Major Accidents? YES/ NO \_\_\_\_\_

Please circle any of the following drugs/ medical treatment you are using:

Antacids	Antibiotics	Anti- depressants	Insulin
Anti-inflammatory	Anti- Psychotics	Blood pressure	Chemotherapy
Heart medication	Hormonal/ cortisone	Hormone replacement	Oral contraceptives
Pain relievers	Sleeping pills	Thyroid drugs	Tranquilizers
Ulcer/ indigestion drugs	Warfarin/ blood thinners	Infectious diseases	Other _____

I understand that payment is due at time of consultation. Generally, Chiropractic and other health providers are 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 adjustments. Disc injury is also possible following neck and back adjustment. Bruising or some achiness may occasionally occur.

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.