connect • advance • thrive

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PERSONAL INFORMATION

Todays Date: _____

Full Name:_____ Preferred Name:_____ Date of Birth:_____

Address:_____ Suburb:_____ Town:_____

Marital Status: *(circle 1) - Single / Married / De-Facto / Divorced* Spouses Name:_____

Phone Number: Home:_____ Work:_____

Mob:_____ ❑ (Please tick if you do not wish to receive SMS communications)

Email Address:_____ ❑ (Please tick if you do not wish to be on our email mailing list)

Emergency Contact:_____ Relationship to you:_____ Contact no:_____

Your Occupation:_____ Your G.P.:_____ Contact no:_____

Previous Chiropractic Care: ❑ *Yes* ❑ *No* If *'yes'* then with whom:_____ Approx last visit:_____

Do you have any children? Names and ages?:_____

How did you find out about us?_____

(If it is an existing patient please tell us their name so we may thank them)

HEALTH HISTORY

People consult our practice with varied health objectives. Please indicate below with a "tick" which apply:

- ❑ Relief of symptoms
- ❑ Correction of my underlying problem
- ❑ Better perform work or recreational activities
- ❑ Improve my health and enhance my quality of life
- ❑ Maximise my own, my family's and my community's health

Please specify your main area of concern_____

_____

_____

_____

What do you think has caused this problem? _____

When did this problem begin? _____

Is the problem getting better, getting worse or unchanged since it began? _____

Was it: ❑ Sudden onset ❑ Gradual onset ❑ Result of an accident - if accident have you filled out an ACC form? Yes / No

Have you had this complaint before in the past? ❑ Yes ❑ No If 'yes' then when?_____

Have you sought care for this problem previously? ❑ Yes ❑ No If 'yes' then when and with whom? (e.g. Physio, Osteo, G.P etc.)

Outcomes of previous care:_____

_____

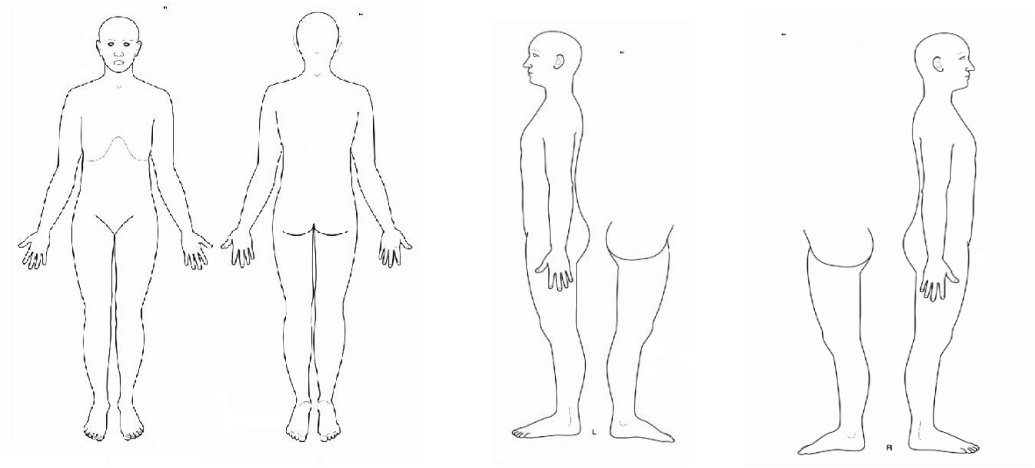
_____

_____

CURRENT PRESENTATION

If you experience **pain, numbness or tingling**, please mark the areas on diagrams with:

P for pain and give it a mark from 1 – 10 *(1 being slight and 10 being unbearable pain)*
N for numbness and **T** for tingling



Please circle the severity of your problem using the following scale if applicable:

1 2 3 4 5 6 7 8 9 10

PAST HISTORY

Have you ever had any trauma? (e.g. car accidents, falls, sports injuries etc) ☐ Yes ☐ No
If 'yes'; when and where? _____

Have you ever broken any bones? ☐ Yes ☐ No if 'yes'; when and where? _____

Have you had any previous surgeries? ☐ Yes ☐ No Surgery (for what specific issue) Date:

Are you on any medications currently? ☐ Yes ☐ No Medication: Reason for taking:
if 'yes' please give the details:

Have you ever been treated for any major illness/conditions? ☐ Yes ☐ No if 'yes' please give details below:

Are there any health problems that run in your family: _____

GENERAL HEALTH

Please tick as appropriate if you have experienced any of the following in the **past** or at the **present:**

Past	Pre	GENERAL
		Headaches / migraines
		Loss of energy
		Depression
		Nervousness or anxiety
		Diabetes
		Cancer
		Stroke
		Allergies or hay fever
		Weight gain / loss
		Concussion
		Epilepsy / convulsions
		Dizziness or fainting spells
		Nausea or vomiting
		Fever / chills
		Night sweats
		Loss of sleep

		EYES, EARS, NOSE &
		Recurring earache(s)
		Ringing in the ears / tinnitus
		Deafness
		Visual disturbances / changes
		Eye pain
		Recurring sinus infection
		Recurring sore throat
		Recurring colds
		Enlarged thyroid / goitre
		Enlarged glands
		Ulcers
		Hoarseness

		WOMENS HEALTH
		Irregular periods
		Painful/heavy periods
		Menopausal symptoms
		Breast Lumps
		Ovarian cysts
		Miscarriage
		Pregnant

Past	Pre	CARDIO-VASCULAR
		Coronary heart disease
		High blood pressure
		Low blood pressure
		Pain over heart
		Poor circulation
		Angina
		Rapid heartbeat
		Slow heartbeat
		Swelling of ankles

		GASTRO-INTESTINAL
		Always hungry / thirsty
		Loss of appetite
		Irritable bowel syndrome
		Food allergies
		Stomach ulcer
		Stomach pain
		Hernia
		Diarrhea
		Constipation
		Difficult digestion
		Inability to control bowel
		Liver trouble / jaundice
		Gallbladder trouble
		Hepatitis
		Vomiting blood
		Bloody stools
		Haemorrhoids
		Reflux / indigestion

		RESPIRATORY
		Difficulty
		Asthma
		Wheezing
		Chronic cough
		Chest pain
		Spitting / coughing up blood
		Tuberculosis (TB)
		Rheumatic fever

Past	Pre	MUSCLE & JOINT
		Arthritis
		Neck pain or stiffness
		Upper back pain
		Shoulder / arm pain
		Low back pain lumbago
		Sciatic / leg pain
		Hip / knee pain
		Ankle / foot pain
		Disc injury
		Muscle weakness
		Gout
		Fractures
		Jaw pain / TMJ
		Pins & needles
		Numbness
		R.S.I. / O.O.S.
		Osteoporosis
		Poor posture
		Spinal curvatures

		GENITO-URINARY
		Frequent urination
		Inability to control
		Painful urination
		Recurring bladder
		Kidney trouble
		Kidney stones
		Prostate trouble
		Blood in urine
		STD's
		Bedwetting

Is there any further information you would like us to know or is relevant to your health care?

LIFESTYLE – physical, chemical and mental stressors

There are three types of stressors that can have a direct impact on our spine and nervous systems resulting in vertebral subluxation. Physical stressors (i.e. accidents/sports, poor posture and/or the birth process); chemical stressors (poor nutrition, drugs/medication and/or environmental toxins); and emotional stressors (relationships, family illnesses, bereavements, work stress); all have major impacts upon our nervous and immune systems.

How many glasses of water do you drink daily? _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

What is your daily caffeine intake? _____

How would you describe your diet? _____

How often do you exercise?_____

What type of exercise do you do? _____

	Excellent				*Poor*
In general, would you say your health is	1	2	3	4	5
In general, would you rate your quality of life is	1	2	3	4	5
In general, how would you rate your physical health ?	1	2	3	4	5
In general, how would you rate your mental health? (including your mood & ability to think)	1	2	3	4	5

In the past **7 days** have you regularly experienced any of the following: (please circle any that apply)

Fatigue/ Tiredness	Grumpiness	Irritability	Anxiety/ Nervousness	Depression	Poor concentration
Insomnia / Poor sleep	Negative thoughts/attitude	Hyperactivity	Anger	Low motivation	Easily losing patience

	Very High	*High*	*Moderate*	*Low*	*Very Low*
How would you rate your current level of stress? (circle)	1	2	3	4	5
In general, how would you rate your satisfaction with your social activities and relationships?	1	2	3	4	5
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend etc.)	1	2	3	4	5
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries etc?	1	2	3	4	5
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	1	2	3	4	5
How would you rate your fatigue on average?	1	2	3	4	5

Consent for Care and Share of Information

Chiropractic care will not commence until this page has been completed.
As with all health care professionals, the law now requires practitioners who adjust the spine to inform patients of material risk. Chiropractic adjustments of the spine are internationally recognised as being safer for neck and low back pain than medication, and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Magna Report, Ontario Ministry of Health, 1993). In extremely rare circumstances, treatment of the neck may result in injury and give rise to a stroke or stroke-like symptoms. This only occurs in approximately 1 in 5.85 million (Halderman et al. Spine 1999 Vol 24-8).
Whilst this has never occurred in this practice, we are still required to impart this information. Before you are adjusted, you will be tested to minimise the risk. If you have any questions related to the care, please speak to your chiropractor.
I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent for Care and Share of Information above.

Patient Signature: _____ Date: ____/____/____
Custodial parent or legal guardian if patient is a minor

Relationship to patient (if minor): _____

Consent to Request Information

In order to obtain a complete health history, it may be necessary for us to request information from other health care professionals or previous chiropractor.

I, _____ , do hereby provide authorisation for this to take place.
Please print full name