Personal Details

CONFIDENTIAL

PLEASE USE A BLACK PEN ONLY AS OUR SCANNER WILL ONLY PICK UP BLACK PEN

NAME:Dr/Mr/Mrs/Ms_____

ADDRESS:_____

_____ POSTCODE:_____

PHONE HOME: _____ PHONE WORK:_____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDATE: _____ OCCUPATION: _____

PARTNER'S NAME: _____ NO. OF CHILDREN: _____

What Health fund do you belong to? _____

Are you covered for chiropractic care (we need to know this as some health funds require specific item numbers)?_____

Is this related to a Workers Compensation [ ] or Third Party Claim [ ] ? [ ] No

Who is your regular doctor (General Practitioner)? _____

We are grateful that our practice grows by referral. Who may we thank for referring you?

_____

Have you ever seen a Chiropractor before?

Yes [ ]

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating your spine and neurological function.

Major Complaint

What is your main problem?_____

_____

When and how did it start? _____

Was there any of the following prior to or during the onset? (Please circle)

Illness / infection

Trauma

Other significant event

Are your symptoms worse at night? Yes / No _____

Is your problem getting worse? Yes / No _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

_____

Are your symptoms worse at night or any specific time of the day? _____

_____

Do you have any pain travelling down your arms or legs? Yes / No If yes, describe

_____

Does your current problem involve any of the following? If Yes, where?

Tingling in either arm or leg Yes / No _____

Numbness in either arm or leg Yes / No _____

Weakness in either arm or leg Yes / No _____

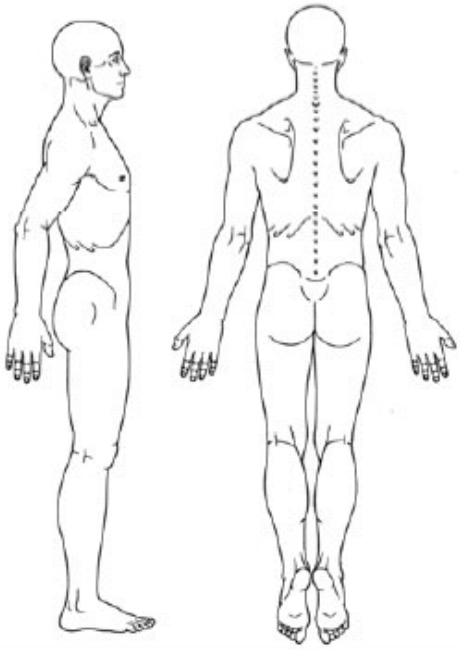
'Weird' sensations in either arm or leg Yes / No_____

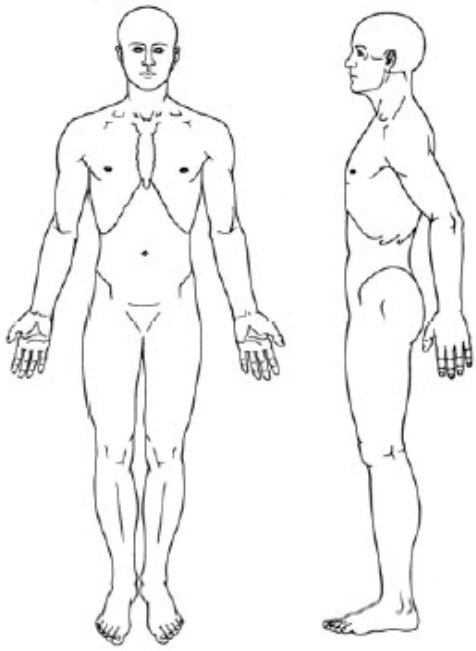
Have you had any other treatment for your current problem? Yes / No _____

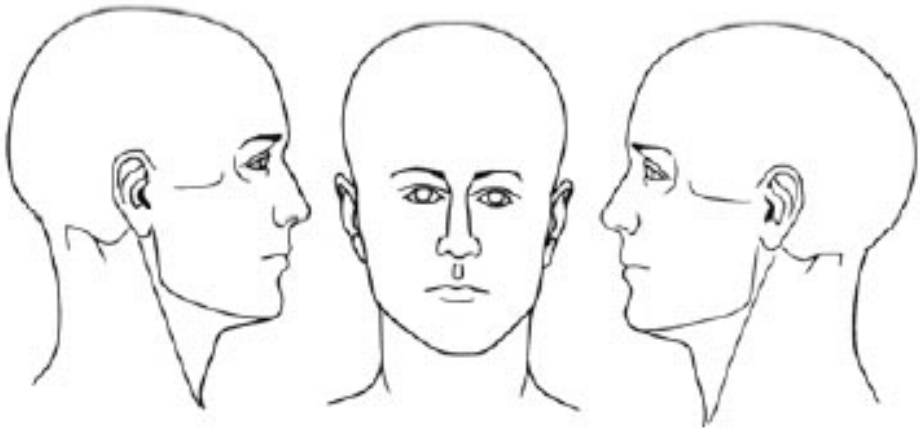
_____

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.







spinescan
chiropractic

Medical History & General Health

Please circle Yes/No where applicable: Describe:

Did you / Do you smoke? Yes / No _____

Did you / Do you drink alcohol? Yes / No _____

Did / Do you take recreational drugs? Yes / No _____

Do you think you have a healthy diet? Yes / No _____

Do you take vitamin supplements? Yes / No _____

Do you exercise regularly? Yes / No _____

Have you had any form of surgery? Yes / No_____

Are you currently taking *any* form of medication? Yes / No If yes list all of them

_____

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No

_____

Have you had any broken bones? Yes / No If yes, which ones and how?

_____

Have you had any car accidents (no matter how trivial)? Yes / No If yes, when and describe_____

Have you had any falls or sports injuries? Yes / No If yes, when and describe

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No

_____

Do you suffer from fatigue? Yes / No _____

Does your heart ever seem to miss a beat? Yes / No _____

Do you suffer with shortness of breath on exertion? Yes / No _____

Are you troubled by pain or tightness in your chest on exertion? Yes / No _____

If yes: Is it relieved by resting? Yes / No _____

Do you suffer with a cramp-like pain in either leg when walking? Yes / No

_____

If yes: Do you have to stop or slow down to relieve it? Yes / No _____

Are you troubled with a frequent or persistent cough? Yes / No _____

Do you have allergy problems? Yes / No _____

Are you troubled with pain or aching in your stomach? Yes / No _____

If yes: Is it relieved by eating or by drinking milk? Yes /No _____

Have you had any persistent change in your appetite during the last three months? Yes / No _____

Has your weight changed more than ten pounds (4 Kg) in the last year? Yes / No _____

Are you troubled with frequent loose bowel movements? Yes / No _____

Are you troubled with constipation? Yes / No _____

Have you noticed any blood or mucus in your bowel movements? Yes / No _____

Are you troubled with haemorrhoids? Yes / No _____

Do you have any pain or difficulty with passing water? Yes / No _____

Are you passing water more frequently lately? Yes / No _____

Do you get pain in any of your joints? Yes / No _____

If yes, is it worse in the night? Yes / No _____

Do your joints ever swell? Yes / No _____

Do you wake up with stiffness or aching in your joints or muscles? Yes / No _____

Have you or your partner noticed any change in your personality? Yes / No _____

Do you have difficulty concentrating? Yes / No _____

Do you have any problems with memory? Yes / No _____

Do you have any problems with hearing (including ringing in the ears)? Yes / No _____

Do you have problems with smell or taste? Yes / No _____

Have you noticed any problems with choosing words or hand writing? Yes / No _____

Did you / Do you have occupational stress? Yes / No _____

Does stress seem to make your main problem worse? Yes / No _____

Are you easily depressed? Yes / No _____

Do you suffer from anxiety? Yes / No _____

Do you have poor sleep? Yes / No _____

Do you grind or clench your teeth? Yes / No _____

Are you often troubled by headaches? Yes / No _____

If yes: Are they accompanied by sickness or other symptoms? Yes / No _____

Do you have any problems with your vision? Yes / No _____

Does one eye water more than the other? Yes / No _____

Do you get cold hands or feet? Yes / No _____

Do you have varicose veins? Yes / No _____

Have you any lumps, cysts, or unusual swellings anywhere on your body? Yes / No

_____

Do you get twitching or cramping anywhere? Yes / No _____

Do you have any problems with sweating? Yes / No _____

Do you have poor balance? Yes / No _____

Did you / Do you suffer vertigo? Yes / No _____

Do you get car/motion sickness? Yes / No _____

Are you subject to blackout, dizzy spells, or faints? Yes / No _____

Do you have a tendency for clumsiness? Yes / No _____

This practice specialises in treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please circle and complete the following: I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

_____ (Signature) _____ (Date)

_____ (Print Name)