
Pain or problem started on: _____

Did it occur at: Home Car accident Sport Work Other

How did it occur? _____

If pain is involved are pains: Sharp Dull Constant Intermittent

Have you had this before: Yes No If "Yes" when? _____

What activities aggravate your condition/ pain? _____

What activities relieve your condition/ pain? _____

Is condition/ pain worse during certain times of the day? _____

Is this condition/ pain interfering with: Work Sleep Routine
Other _____

Is condition/ pain getting progressively worse? _____

Other treatment for this problem:

GP Physiotherapy Specialist Acupuncture Counseling Other

Treatment given: _____

Do you have x-rays available: Yes No

What areas were x-rayed? _____

Any home remedies? _____

Other symptoms: Please tick (✓) any of the following conditions you have now.
Please cross (X) any of the conditions which you have had in the past.

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Popping, clicking or pain in jaw joints | |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Tension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Blind spot in vision | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Ears ring | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Eczema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Regular colds and flu | <input type="checkbox"/> Loss of memory | |
- Other _____

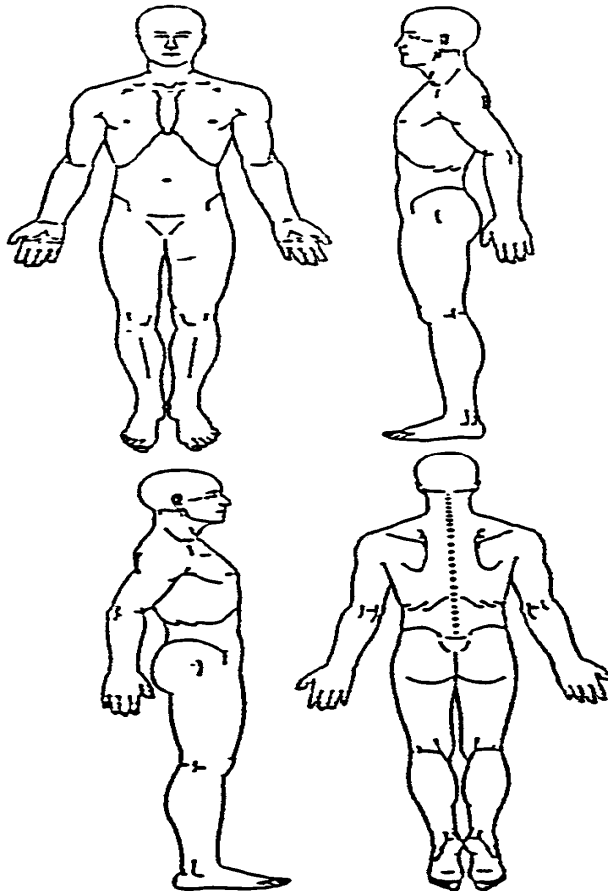
FEMALE CONDITIONS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Congested breasts | <input type="checkbox"/> Cramps or backache | <input type="checkbox"/> Hot flushes |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Irregular cycles |
| <input type="checkbox"/> Lumps in breasts | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Altered sex drive | |

MALE CONDITIONS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Impotence | <input type="checkbox"/> Undescended testicles |
| <input type="checkbox"/> Groin pain | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Altered sex drive | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Poor sperm morphology |

Please mark on the diagram below where your complaint areas are:



Additional information:

Yes No

- Are you aware if you had a difficult birth/ eg. were forceps used etc.?
- Were you a cesarean birth?
- Did you have any surgery as a child?
- Did you have any accidents as a child? eg. sports injuries, falls etc.
- Did you "headbang" as a child ? (Indicates cranial/skull problems)
- Did you have any orthodontic care or teeth extracted?
- Did you have any recurring infections? (Tonsils/ Ears/ Sinus/ Urinary tract/ Kidneys etc.)
- Have you ever had any surgery?
- Have you had any major sports injuries as an adult?
- Do you smoke? Yes No Have you ever smoked?
- Do you drink? Yes No Have you ever drank?
- Do you have a balanced diet?
- Do you drink coffee/tea? Yes No How many cups daily? _____
- Do you have sugar in your diet? Intake per day? _____
- Do you crave sugar?
- Do you exercise regularly?
- Do you have occupational stress?
- Physical stress?
- Mental stress? Relationship stress? Family stress?
- Do you sleep well?
- Sleeping posture: Side Stomach Back Mixture
- Do you wear any lift or support (orthotics) in your shoes?
- Have you had any dental work in the past 5 years?

PLEASE LIST ANY OPERATIONS/ SURGERIES YOU HAVE HAD:

Year/Age _____ Operation _____
Year/Age _____ Operation _____

PLEASE LIST ALL ILLNESSES, DISEASES, AND CONDITIONS YOU HAVE HAD:

Year/Age _____ Disease _____
Year/Age _____ Disease _____
Year/Age _____ Disease _____

HAVE YOU EVER BEEN IN ANY ACCIDENT? (WORK, CAR, SPORT, OTHER). IF SO LIST BELOW:

Year _____ Type of accident _____ Injuries _____
Year _____ Type of accident _____ Injuries _____
Year _____ Type of accident _____ Injuries _____

HAVE YOU EVER FRACTURED/ BROKEN ANY BONES? IF SO LIST BELOW:

Year _____ Which bone _____
Year _____ Which bone _____
Year _____ Which bone _____

PLEASE LIST ALL X-RAYS YOU HAVE HAD IN THE PAST FIVE YEARS:

Year _____ Part x-rayed _____
Year _____ Part x-rayed _____
Year _____ Part x-rayed _____

ARE YOU TAKING ANY MEDICATION, TABLETS, DRUGS, HERBS, VITAMINS OR HOMEOPATHIC REMEDIES?

Name of remedy _____ What for? _____
Name of remedy _____ What for? _____
Name of remedy _____ What for? _____

Health problems may be the result of hereditary factors or inherited spinal weaknesses. This information about your family members will give us a better idea of your total health picture.

<u>Name</u>	<u>Relation</u>	<u>Past and present health problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are female, is there any possibility that you may be pregnant? _____

CREDIT and CANCELLATIONS POLICY

It is a policy of this practice to expect payment for treatment on the day it is provided. We accept Cash/ Cheque/ EFTPOS/ Credit Card/ HICAPS.

I understand that in event of a cancellation where less than 24 hours notice is given and the appointment cannot be filled, a charge of \$20 will be incurred. If less than three hours notice is given I understand that a fee of \$20 will be automatically incurred. I also understand that non-attendance at appointments automatically incurs the appointment fee.

Signature Parent/Guardian _____

Please Print Name _____

Date _____

PATIENT CONSENT FORM

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx 1 in 5.85 mil neck manipulations. Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). [Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.]

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)

If you have any questions related to the treatment you are about to receive, please speak to the chiropractor.

I have discussed the above information with the chiropractor and give my consent to treatment.

Patient's signature _____

Print name here _____

In the case of a patient under 18 years, a parent or legal guardian must sign:

Patient's Name _____

Parent / Legal Guardian's signature _____

Parent / Legal Guardian's name _____

Chiropractor's signature _____

Date _____

**INFORMATION REGARDING WORKERS COMPENSATION & MOTOR
VEHICLE ACCIDENT CLAIMS**

If you have an accident at work or motor vehicle accident that would entitle you to claim damages, please note that the writing of reports and dealing with insurance agencies is **not a service we offer at any Care Clinic location.**

If a case should arise, we will assist you in contacting the Chiropractors Association of Australia so you can get the help you need with these kinds of matters.

Please sign below to confirm you understand Care Clinic does not offer services in relation to workers compensation or vehicle accident claims. Your presenting condition and care required is of a private nature and unrelated to any workers compensation insurance, third party or any other insurance or legal matter.

In the case of a patient under 18 years, a parent or legal guardian must sign:

Patient's Name _____

Parent / Legal Guardian's name _____

Patient/ Parent / Legal Guardian's signature _____

Chiropractor's signature _____

Date _____