Website Membership Enrollment

The information on our website will help you

Get Well

Stay Well

Please provide the following details so we can establish you as a member of our website today.

First Name _____

Last Name _____

Date of Birth ____/____/____

Email Address _____

By joining our website, you authorize us to send healthcare related emails to you.
You may opt -out at anytime. Please review our complete privacy policy on our website

Where did you find out about our clinic?

Signage ☐

Website ☐

Family/Friend ☐ (Please supply name) .....

Google Reviews ☐

Facebook ☐

Other ☐ (Please state).....

FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT RECORD

(PLEASE PRINT) DATE.....

NAME..... AGE ..... DATE OF BIRTH.....

ADDRESS..... POSTCODE.....

TEL (H)..... TEL (W)..... MOBILE..... EMAIL.....

OCCUPATION..... EMPLOYER.....

ADDRESS..... IS THIS A PERSONAL INJURY CASE? YES/NO

NO. OF CHILDREN..... AGES.....

NEXT OF KIN-NAME.....TEL NO. .....

HOW DID YOU HEAR ABOUT US? FAMILY/FRIEND ☐ SIGNAGE ☐ GOOGLE ☐ SOCIAL MEDIA ☐

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO WITH DR..... IN YEAR?.....

I WOULD LIKE HELP FOR .....

ANY FAMILY HISTORY OF THE PROBLEM? YES/NO .....

OTHER PROBLEMS I AM CONCERNED WITH .....

.....

.....

CAR ACCIDENT(S) YES/NO, WHEN?.....

INJURIES SUSTAINED?.....

.....

OTHER PERSONAL INJURIES/ACCIDENTS? YES/NO,

WHEN?.....

INJURIES SUSTAINED?.....

.....

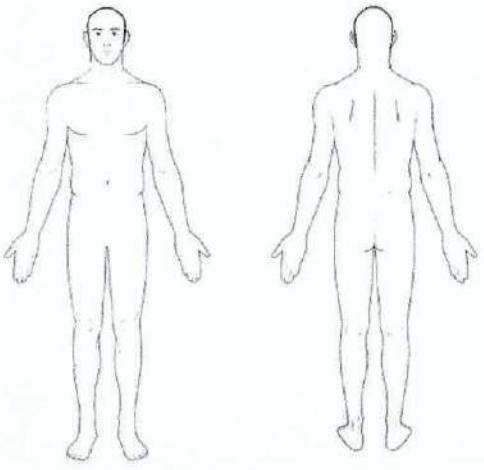
EXERCISE PROGRAM/ SPORTING ACTIVITES? YES/NO
WHAT?

.....

SUPPORTS FOR BACK/FEET?...

.....

PLEASE ILLUSTRATE AFFECTED AREAS



DO YOU SLEEP ON YOUR SIDE/BACK/STOMACH?.....TYPE OF MATTRESS?.....PILLOW?.....

ANY PAST SURGERY?.....

.....

DRUGS/MEDICINES/VITAMINS-TYPE/DOSAGE, etc.....

.....

FAMILY CHIROPRACTIC

HAVE YOU SUFFERED OR ARE YOU SUFFERING FROM ANY OF THE FOLLOWING? – **TICK APPROPRIATE BOXES**

PAST PRESENT		PAST PRESENT		PAST PRESENT	
☐☐	PINS AND NEEDLES OF HANDS	☐☐	SCALP DISORDERS	☐☐	ASTHMA
☐☐	LOSS OF GRIP	☐☐	PAIN IN HEAD	☐☐	CHRONIC COUGH
☐☐	WRIST OR HAND PAIN	☐☐	SORENESS IN NECK	☐☐	STOMACH TENSION
☐☐	MID BACK PAIN	☐☐	SHOULDER PAIN	☐☐	DIGESTIVE MALFUNCTION
☐☐	MID BACK TENSION	☐☐	SHOULDER STIFFNESS	☐☐	NAUSEA
☐☐	PAIN IN RIBS	☐☐	SHOULDER TENSION	☐☐	ALLERGIES
☐☐	LOW BACK PAIN	☐☐	ARM PAIN	☐☐	VOMITING
☐☐	LOW BACK WEAKNESS	☐☐	ELBOW PAIN	☐☐	CONSTIPATION
☐☐	LOW BACK STIFFNESS	☐☐	LOSS OF ARM POWER	☐☐	DIARRHOEA
☐☐	HIP PAIN OR STIFFNESS	☐☐	EYE DISORDERS	☐☐	ABDOMINAL PAIN
☐☐	BUTTOCK PAIN	☐☐	LOSS OF TASTE	☐☐	PILES
☐☐	LEG PAIN	☐☐	HEADACHES	☐☐	URINARY DISORDERS
☐☐	LEG CRAMPS	☐☐	NERVOUSNESS	☐☐	BED WETTING
☐☐	PINS AND NEEDLES OF LEGS	☐☐	INSOMNIA	☐☐	MENSTRUAL DISORDERS
☐☐	KNEE TROUBLE	☐☐	DIZZINESS	☐☐	LOSS OF POTENCY
☐☐	FOOT OR ANKLE TROUBLE	☐☐	LOSS OF SMELL	☐☐	OTHER SEXUAL DISORDER
☐☐	PINS AND NEEDLES OF FEET	☐☐	SINUS TROUBLE	☐☐	TENSION CHRONIC
ANYTHING ELSE?.....		☐☐	EAR DISORDERS	☐☐	IRRITABILITY CHRONIC
		☐☐	HAY FEVER	☐☐	FATIGUE CHRONIC
.....		☐☐	RECURRENT SORE THROAT	☐☐	SLEEPING PROBLEMS

HOW MUCH WATER DO YOU DRINK PER DAY?..... HOW MANY CANS/BOTTLES OF FIZZY POP PER DAY?.....

HOW MANY CUPS OF TEA/COFFEE PER DAY?..... HOW MANY UNITS OF ALCOHOL PER WEEK?..... DO YOU SMOKE? Y/N

FOR WOMEN ONLY:

IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT NOW? Y/N . IF SO, HOW MANY WEEKS?.....

DATE OF FIRST DAY OF LAST PERIOD..... PAST PREGNANCIES? HOW MANY?.....

LIVE BIRTHS: HOW MANY? ..... WERE THE BIRTHS TRAUMATIC? YES/NO, PLEASE EXPLAIN (FORCEPS, EPISIOTOMY, C-SECTION, VENTOUSE/SUCTION, PROLONGED LABOUR, ETC).....

.....

FOR MEN ONLY

HAVE YOU EVER SUFFERED WITH PROSTATE TROUBLE? YES/NO.....

.....

I DECLARE THAT I HAVE PROVIDED ALL THE INFORMATION REQUESTED TO THE BEST OF MY KNOWLEDGE, AND I NOW CONSENT TO A PHYSICAL EXAMINATION AND A POSTURE SCREEN.

SIGNED.....PATIENT NAME.....DATE.....

PLEASE TICK THE BOX IF YOU CONSENT TO HAVING YOUR POSTURE SCREEN IMAGES USED FOR ILLUSTRATIVE PURPOSES ON SOCIAL MEDIA ☐

PATIENT REPORTED OUTCOME MEASURE (Pre QUESTIONNAIRE)

NAME..... DATE..... Height.....cm ... .ft.....ins."

Weight .....Kg .....lbs

This questionnaire is about the complaint that has brought you into the clinic today.

By completing this form, you consent to your information being used anonymously and in confidence, to evaluate your treatment for research purposes. It may also be used by your clinician to monitor your progress. Tick ONE BOX for EACH question unless instructed otherwise.

Q1. Over the past few days, on average, how would you rate your pain on a scale where "0" is no pain and "10" is "the worst pain?"

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q2. Over the past few days, how BOTHERSOME or TROUBLESOME has this complaint been?

Not at all..☐ Slightly..☐ Moderately...☐ Very much...☐ Extremely...☐

Q3. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)? "0" is "not at all" and "10" is "has severely affected daily activities?"

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4 Over the past few days, on average how has this complaint interfered with your normal social routine including recreational, social and family activities, on a scale where "0" is no interference and "10" is "completely unable to participate in any social or recreational activity?"

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q5. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where "0" is "not at all anxious" and "10" is "extremely anxious?"

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q6. Over the past few days, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where "0" is "not at all depressed" and "10" is "extremely depressed"?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q7. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected this complaint, on a scale where "0" is "made it no worse" and "10" is "made it much worse"?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q8. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own, on a scale where "0" is "I can control it completely" and "10" is "I have no control whatsoever?"

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐