

WELCOME TO

PATIENT FILE NO. _____

Date: _____

Confidential Patient History

Welcome to our practice! Please complete all questions and PRINT clearly.

PERSONAL DETAILS

Surname: _____ First Name: _____

Address: _____ Suburb: _____ Postcode: _____

Home Ph: _____ Work Ph: _____ Mob: _____

D.O.B.: ____ / ____ / ____ Sex: M / F Email: _____

Occupation: _____ Employed by: _____

Type of work: Sitting Computer Standing Driving Lifting Other: _____

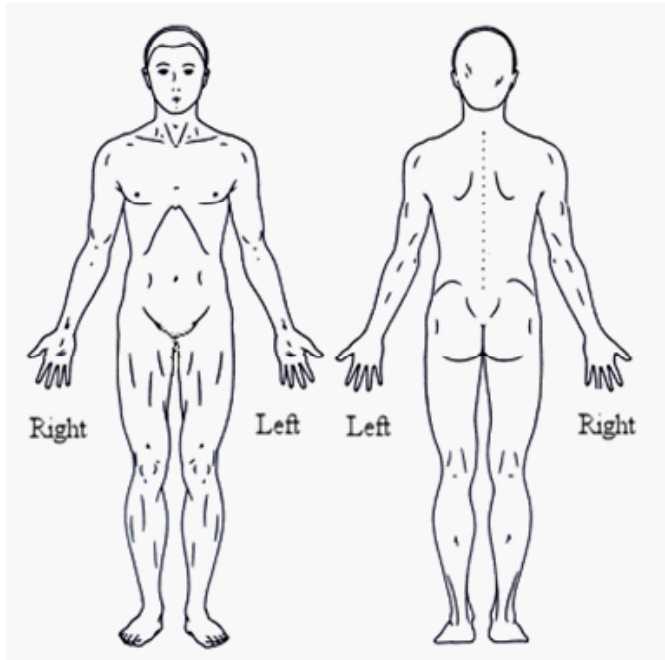
Spouse's Name: _____

Children(s) Name(s) & Age(s): _____

Method of payment for first visit: Cash Cheque Credit Card Eftpos

Do you have private health insurance: Yes / No If yes, which fund? _____

Whom may we thank for referring you to our practice? _____



WHERE IS YOUR PAIN?

Please mark areas of complaint on the chart (to the left) and indicate the type of pain using the following legend:

Numbness	Pins & Needles	Burning	Aching	Stabbing
_____	OOOOO	XXXX	*****	////////

Neck / Shoulder / Arm Pain

on a scale of 1 – 10, I rate my discomfort as _____
(0 no pain) 10 (severe pain)

Mid Back Pain

on a scale of 1 – 10, I rate my discomfort as _____
(0 no pain) 10 (severe pain)

Low Back and Leg Pain

on a scale of 1 – 10, I rate my discomfort as _____
(0 no pain) 10 (severe pain)

SYMPTOMS YOU ARE EXPERIENCING

Please list your chief complaints in order of severity, or tick here if your reason for attending is to improve **Health & Wellness**

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the main problem? _____

Is the pain: Sharp Dull Aching Burning Throbbing Like pins & needles

Continued over

Does the pain spread? Yes / No If yes, where? _____

Do you have numbness? Yes / No If yes, where? _____

Is there pain when you cough or sneeze? Yes / No If yes, where? _____

Is there pain when you sit or stand? Yes / No If yes, where? _____

Is the pain getting progressively worse? Yes / No Constant Comes & Goes

Do you have headaches? Yes / No If yes, circle all that apply:
Tension Throbbing Sinus Migraines or Other: _____

Indicate any function below that aggravates or are aggravated by your condition (please circle all that apply):

Walking Steep climbing Driving Working Recreation Bowel movements Digestion
Vision Breathing Sinuses Hearing Smelling Sleeping If female, menstruation

Have you ever been to a chiropractor before? Yes / No If yes, when? _____

What do you think is wrong? _____

What do you think caused the problem? _____

Please list the doctors who were consulted for these conditions:

- 1. _____ Diagnosis given: _____
- 2. _____ Diagnosis given: _____
- 3. _____ Diagnosis given: _____

Please list any operations you have had:

- 1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had:

- 1. _____ 2. _____ 3. _____

Date of last physical: ____ / ____ / ____

Is there any chance that you are pregnant? Yes / No

Have you ever been diagnosed with cancer? Yes / No If yes, what kind? _____

Medication you currently take: _____

Does your father, mother, sister or children have similar problems? Yes / No If yes, who: _____

When the pain is at its worst, how does it feel? _____

Does this Cause you to Be:	Does this affect your Work:	Does this affect your life:
<input type="checkbox"/> Moody	<input type="checkbox"/> Decision Making	<input type="checkbox"/> Lose patience with your family
<input type="checkbox"/> Irritable	<input type="checkbox"/> Poor attitude	<input type="checkbox"/> Restricted household duties
<input type="checkbox"/> Interrupt sleep	<input type="checkbox"/> Decreased Productivity	<input type="checkbox"/> Can't exercise or play Sport
<input type="checkbox"/> Restrict your daily activities	<input type="checkbox"/> Exhausted at end of Day	<input type="checkbox"/> Interference with hobbies/activities

CHIROPRACTIC HEALTH QUESTIONNAIRE

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of your condition. Please tick the appropriate box if you have had any of the following symptoms in the past **6 months**. *Leave blank any that do not apply.*

(O=Occasionally, F= Frequently, C=Constantly)

	O	F	C			O	F	C	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head	52.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary System
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	53.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light Headedness	54.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance	55.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Starting Urine
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	56.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling Urine
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	57.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Controlling Urine
				Buzzing in Ears	58.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
				Neck	59.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	60.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ache	61.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Trouble
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soreness/Stiffness					Females Only
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grating Sensation	62.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or Tender Breasts
				Shoulder, Arm or Fingers	63.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Breasts
11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	64.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Period Pains
12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins/Needles Sensation	65.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Menstrual Flow
13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness Sensation	66.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scanty Menstrual Flow
14.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Movement	67.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods
15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	68.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Between Periods
16.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Strength	69.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flushes
				Chest	70.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Symptoms
17.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Chest	71.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain around Ribs	72.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse
19.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	73.	_____			Number of Children you Have
20.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	74.	_____			No. of miscarriages if any
21.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tightness around Chest	75.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Symptoms
22.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	76.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
23.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thumping Heart	77.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
				Stomach or Abdomen	78.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills
24.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Stomach	79.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
25.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Excessive Wind	80.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
26.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	81.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
27.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Stomach	82.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Sensation
28.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	83.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fatigue
29.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	84.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fevers
30.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	85.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Loss of Weight
31.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhoea	86.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep
32.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	87.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
33.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	88.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
34.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	89.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweating Excessively
35.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Groin Pain	90.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
				Low Back, Legs or Feet	91.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
36.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	92.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
37.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins/Needles Sensation	93.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
38.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness Sensation					
39.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Movement					
40.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints					

INFORMED CONSENT

Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug-free health care profession in the world.

Due to recent major world events and changes in the health and insurance industries, we want to inform you of the possible risks associated with chiropractic care.

1. You will be tested before any adjustments are applied;
2. Sometimes you may get **pain**, a strain to a ligament or disc, or an aggravation of the underlying condition from a perfect adjustment. This may happen just like a good massage or gym session. If this occurs please call straight away, there are things your Chiropractor can do to help.
3. If this occurs you may even require a 2nd adjustment. We **never charge if you need a 2nd adjustment on the same day.**
4. Accidents are extremely rare and the risk of damage to neck blood vessels, which can arise in stroke or like symptoms.
5. Chiropractic adjustments of the spine are internationally recognised as being far safer than medications and many other alternatives (see below).
6. The proposed Diagnostic imaging procedure has been explained to me in full and I have had the opportunity to ask questions."

I acknowledge the above information and do not expect the Chiropractor to be able to anticipate all potential risks and complications. Based on all the information provided, I consent to and look forward to receiving Chiropractic care at this office.

Patient Name

(Please sign at appointment)

Patient/Guardian Signature

(Please sign at appointment)

Dr. Andrew Gorman
CHIROPRACTOR

Chiropractor Signature

Cervical Spine (Neck)

(temp) Radiculopathy associated with disc injury 1:139,000

Vascular Injury 1:5.85million

Lumbar Spine

Disc injury with radiating pain 1:62,000

Radiculopathy 1:188,000

Cauna Equina Syndrome 1:656,000

In Comparison

Hospitalisation for Gastro-Intestinal Bleeding (NSAID) (following one month of medication) 1:250

Deaths associated with NSAID's (US) 3200 p.a
(AUS) 360 p.a

Death from general anaesthetic 1:1250

Death from Cancer (all kinds) 1:555

Injury from Motor Vehicle Accident 1:93,000

Hospitalisation for adverse drug reactions 20,000 to 26,000 p.a

Privacy Act 1988 (Commonwealth)

This Chiropractic Office complies with the above act; Information provided by you is collected with a view to helping you with your health concerns. It is not used or disclosed to any third parties or organisations, other than required by our professional advisors (e.g. insurers) or required by law.

To keep you abreast of news, developments and activities at our office, you will be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities etc. Additionally, we may contact you in relation to your care. We require your permission to contact you, either by post, fax, email, telephone or otherwise.

PATIENT SIGNATURE

DATE

OFFICE USE ONLY – Patient Matching

NAME	DOB	ADDRESS	GENDER	RECORD NUMBER