WELCOME TO Andrew Gorman Chiropractic

more choice and control of your health

PATIENT FILE NO. _____

Confidential Patient History

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

Date: _____

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): _____

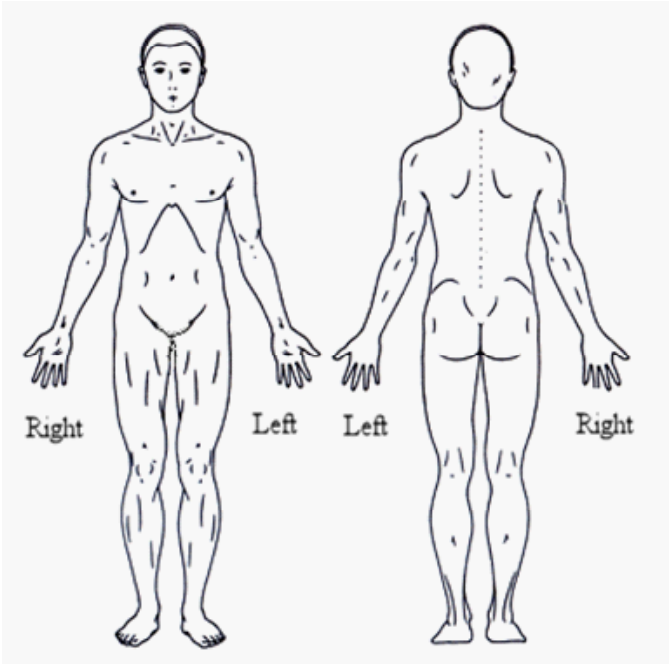
EMERGENCY CONTACT DETAILS

Name: _____ Phone: _____ Relationship: _____

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:
☐ Moody	☐ Decision Making	☐ Lose patience with your family
☐ Irritable	☐ Poor attitude	☐ Restricted household duties
☐ Interrupt sleep	☐ Decreased Productivity	☐ Can't exercise or play Sport
☐ Restrict your daily activities	☐ Exhausted at end of Day	☐ 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	
				Head
1.	☐	☐	☐	Headaches
2.	☐	☐	☐	Light Headedness
3.	☐	☐	☐	Loss of Balance
4.	☐	☐	☐	Hearing Loss
5.	☐	☐	☐	Ringing in Ears
6.	☐	☐	☐	Buzzing in Ears
				Neck
7.	☐	☐	☐	Pain
8.	☐	☐	☐	Ache
9.	☐	☐	☐	Soreness/Stiffness
10.	☐	☐	☐	Grating Sensation
				Shoulder, Arm or Fingers
11.	☐	☐	☐	Pain
12.	☐	☐	☐	Pins/Needles Sensation
13.	☐	☐	☐	Numbness Sensation
14.	☐	☐	☐	Restricted Movement
15.	☐	☐	☐	Swollen Joints
16.	☐	☐	☐	Loss of Strength
				Chest
17.	☐	☐	☐	Pain in Chest
18.	☐	☐	☐	Pain around Ribs
19.	☐	☐	☐	Shortness of Breath
20.	☐	☐	☐	Wheezing
21.	☐	☐	☐	Tightness around Chest
22.	☐	☐	☐	Rapid Heart Beat
23.	☐	☐	☐	Thumping Heart
				Stomach or Abdomen
24.	☐	☐	☐	Nervous Stomach
25.	☐	☐	☐	Belching or Excessive Wind
26.	☐	☐	☐	Nausea
27.	☐	☐	☐	Pain in Stomach
28.	☐	☐	☐	Gall Bladder Trouble
29.	☐	☐	☐	Liver Problems
30.	☐	☐	☐	Constipation
31.	☐	☐	☐	Diarrhoea
32.	☐	☐	☐	Colitis
33.	☐	☐	☐	Excessive Hunger
34.	☐	☐	☐	Hernia
35.	☐	☐	☐	Groin Pain
				Low Back, Legs or Feet
36.	☐	☐	☐	Pain
37.	☐	☐	☐	Pins/Needles Sensation
38.	☐	☐	☐	Numbness Sensation
39.	☐	☐	☐	Restricted Movement
40.	☐	☐	☐	Swollen Joints

	O	F	C	
				Genito-Urinary System
41.	☐	☐	☐	Frequent Urination
42.	☐	☐	☐	Painful Urination
43.	☐	☐	☐	Difficulty Starting Urine
44.	☐	☐	☐	Dribbling Urine
45.	☐	☐	☐	Difficulty Controlling Urine
46.	☐	☐	☐	Bed Wetting
47.	☐	☐	☐	Kidney Infection
48.	☐	☐	☐	Bladder Infection
49.	☐	☐	☐	Prostate Trouble
				Females Only
50.	☐	☐	☐	Painful or Tender Breasts
51.	☐	☐	☐	Lumps in Breasts
52.	☐	☐	☐	Period Pains
53.	☐	☐	☐	Excessive Menstrual Flow
54.	☐	☐	☐	Scanty Menstrual Flow
55.	☐	☐	☐	Irregular Periods
56.	☐	☐	☐	Bleeding Between Periods
57.	☐	☐	☐	Hot Flushes
58.	☐	☐	☐	Menopausal Symptoms
59.	☐	☐	☐	Vaginal Discharge
60.	☐	☐	☐	Painful Intercourse
61.	_____			Number of Children you Have
62.	_____			No. of Miscarriages (If any)
				General Symptoms
63.	☐	☐	☐	Allergies
64.	☐	☐	☐	Sinus Trouble
65.	☐	☐	☐	Chills
66.	☐	☐	☐	Convulsions
67.	☐	☐	☐	Dizziness
68.	☐	☐	☐	Asthma
69.	☐	☐	☐	Fainting Sensation
70.	☐	☐	☐	Excessive Fatigue
71.	☐	☐	☐	Fevers
72.	☐	☐	☐	Sudden Loss of Weight
73.	☐	☐	☐	Loss of Sleep
74.	☐	☐	☐	Nervousness
75.	☐	☐	☐	Depression
76.	☐	☐	☐	Sweating Excessively
77.	☐	☐	☐	Tremors
78.	☐	☐	☐	Poor Circulation
79.	☐	☐	☐	High Blood Pressure
80.	☐	☐	☐	Low Blood Pressure

1. Postural distortions run in families and people with similar activities. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problems? Yes / No

2. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Yes / No

3. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? Yes / No

4. A poorly functioning spine and nervous system can affect the way your entire body functions. Does the problem affect your work or any sports/hobbies you enjoy? Yes / No

5. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

   Poor 1 2 3 4 5 6 7 8 9 10 Excellent

6. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days:

   Low 1 2 3 4 5 6 7 8 9 10 High

7. Are you presently taking any vitamins or other health supplements? Yes / No

   If yes, for what reason? _____

8. Are you a smoker? Yes / No

   If yes, how many cigarettes per day? _____

9. If you had Chiropractic Care before, please complete the following:

   Name of Chiropractor: _____

   Located Where: _____ How many adjustments were given: _____

   How frequent: _____ When was your last adjustment: _____

   Did you have X-rays: Yes / No

   What type of care were you under: ☐ Initial Intensive Care ☐ Spinal Reconstructive ☐ Wellness Care ☐ Don't know

YOUR HEALTH GOALS

The purpose of this section is to enable your chiropractor to know what your health objectives are, what your expectations are and what is important to YOU. *(Please circle or tick your answer).*

10. Are you happy with the way you look and feel? Yes / No

11. How long has it been since you have felt your best? ☐ Years ☐ Months ☐ Days

12. How long have you been thinking about pursuing your health goals? ☐ Years ☐ Months ☐ Days

13. What are you most interested in improving? ☐ Overall health ☐ Less pain/symptoms ☐ Reducing stress ☐ Increasing your energy and vitality

14. How long do you think it will take to achieve your health goals? ☐ Years ☐ Months ☐ Days

15. Please list your desired health goals and the areas you are most interested in improving: _____

_____

_____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

DOCTOR SIGNATURE DATE

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) (AUS)	3200 p.a 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