Welcome to the Toowoomba Clinic for Spine Related Disorders

CONFIDENTIAL

Please use a black Pen

Personal Details

Name - Dr / Mr / Mrs / Miss / Ms.....

Address ..... Postcode .....

Home Phone ..... Work Phone ..... Mobile .....

Birthdate ..... Occupation ..... No. of Children .....

Email ..... Partner's Name.....

Emergency Contact Name ..... Phone.....

Relationship to you.....

Health Fund Name? ..... Are you covered for Chiropractic care? **Yes / No**

Is this related to a Workers Compensation Claim? **Yes / No** or a Third Party Claim? **Yes / No**

Doctor's Name & Location (GP).....

Do you give permission for your chiropractor to communicate with your GP? **Yes / No**

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

.....

Have you seen a Chiropractor before? **Yes / No** *(If not, then don't worry, we will explain everything as we go and only proceed once you are completely comfortable)*

Would you like to receive a monthly Health and Wellbeing newsletter by email? **Yes / No**

If yes, please tick the health subjects that most interest you:

( ) Headaches and Neck Pain
( ) Backaches and Sciatica
( ) Children's Health Issues
( ) Women's Health Issues
( ) Golf / Sport
( ) Wellness Topics
( ) Diet and Nutrition
( ) Exercise and Fitness
( ) Stress Management

Medical History & General Health

What medications are you currently taking? .....

.....

Have you had any surgery during your life?.....

.....

Please list any physical trauma during your life? (eg falls, car accidents, sport injuries, work injuries, broken bones, sprains) .....

.....

Please list any chronic diseases you have (eg cancer, diabetes, heart disease, obesity). .....

.....

Please complete the information as accurately as possible, as it will help us to evaluate your spine and neurological function

Major Complaint

What is your main problem? .....

When and how did it start? .....

How does this problem rate on a scale of 0 to 10? (0 nothing, 10 bad) .....

Were there any of the following prior to, or during the onset? **(*Please circle all appropriate*)**

Illness / infection / Trauma / Other Significant Event / Emotional Stress.....

Is your problem getting worse? **YES / NO** What relieves your symptoms? .....

What aggravates your symptoms? .....

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

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

Pain 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**.....

Poor balance **YES / NO** .....

Restricted movement **YES / NO**.....

Have you had any other treatment for you current problem? **YES / NO If yes, where?**.....

Is this complaint interfering with any activities? eg sleep, work, sport, hobbies, other? **YES / NO** .....

.....

What are your goals with care? eg Full recovery with full function and no pain, less pain? .....

.....

Where is the Problem?

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