Confidential Patient Questionnaire

Name:_____Title:_____Date: _____

Address: _____Suburb_____Postcode: _____

Occupation:_____Employer's Name_____

Telephone:_____Work: _____Mobile: _____

Email Address:_____DOB: ____/____/____ Age: ____

Can we subscribe you to our website/newsletter? ❒Yes ❒No (Naturally you can unsubscribe any time.)

Name of Partner: _____Name of Children & ages: _____

How did you find us? ❒Internet ❒Yellow Pages ❒Sign ❒Client Referral ❒Other_____

Which of our patients referred you? _____

Insurance Company:_____

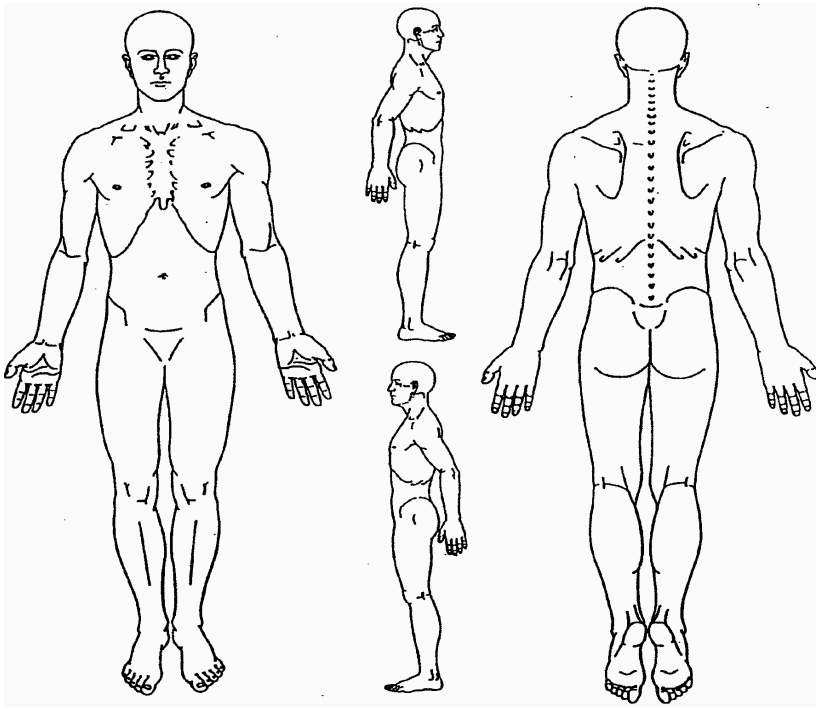
Please mark (circle/cross) the entire area of your pain or problems on the diagram opposite. Use the letters below to indicate the location and extent of your problems.

P – Pain **S** – Stiffness

N – Numbness **B** – Burning

H – Heat **C** - Cold sensations

T - Tingling **Z** – Other sensations



Please list your major complaints.

_____

_____

_____

_____

_____

How can we help you?

❒ **Relief care** – Symptomatic relief of pain or discomfort

❒ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❒ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible

❒ I want the Doctor to select the type of care appropriate for my condition.

YOUR PURPOSE

What would you like to achieve by coming to our clinic? (please tick)

Also, what would you like to achieve in general in your life? (please circle)

☐ Reduce pain	☐ Reduce anxiety	☐ Improve concentration
☐ Improve energy	☐ Help with weight issues	☐ Stress management
☐ Nutrition	☐ Improve general health	☐ Improve memory
☐ Exercise	☐ Help with allergies	☐ Emotional issues

Other: _____

How would you rate your overall health at this point?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Terrible **Great**

OUR PURPOSE

Our number one purpose is to serve you as a unique individual with specific health needs and wants. We believe the more information you have about your state of being, the more you are able to make a positive decision, one that affects your whole body & health for the betterment of yourself and your loved ones. Our aim is to help You reach your optimal health and well-being, feel energised, achieve vitality by understanding your body through the wonderful healing nature of chiropractic and other complementary therapies.

Please list *every* fall, accident, motor vehicle accident, fracture or dislocation.

_____

_____

Please list *all* surgical procedures and year.

_____

Please list all previously contracted diseases (i.e. chickenpox, flu, measles, lyme disease…etc.).

_____

How did your major current condition start or happen and when?

_____

Have you received any treatment for your main complaint(s)? What type?

_____

Do you have current (<2yr) X-rays, blood tests, CT scans or MRI's? _____

Who is your GP? _____

Are you on any medications, painkillers, tranquillisers, contraceptive or other drugs?

_____

Have you ever been to a Chiropractor before? Who? When?

_____

Have you ever been to a Naturopath before? Who? When? Do you take any natural medicine, vitamins or herbs?

_____

_____

Do you **smoke**? ❒ How many per day (really!!!) _____

How much of these substances do you drink per day?

☐ **Tea** _____ cups per day. ☐ **Fizzy drinks** _____ per day. ☐ **Alcohol** ___ unit(s) per day.

☐ **Coffee** _____ cups per day. ☐ **Diet drinks** _____ per day. ☐ **Water** _____ cups per day.

☐ **Coke** _____ per day. ☐ **Energy drinks** ___ per day.

Your birth was: ❒ Natural ❒ Caesarean ❒ Forceps ❒ Don't know ❒ Other complications_____

Do you have dental mercury? ❒ Yes ❒ No Have you had dental surgery? ❒ Yes ❒ No

Have you had root canal(s) done? ❒ Yes ❒ No Do you have dental check ups regularly? ❒ Yes ❒ No

Your bed is _____ years old. ❒ Latex ❒ Springs ❒ Waterbed ❒ Memory Foam ❒ Other_____

Exercise

❒ Never ❒ 1-2 hours a day. ❒ 1-2 days a week. ❒ Other_____

You spend _____ hours outside a day / a week. (Please circle.)

What activities would you like to be able to do when you regain your health?

_____

Have you experienced or had any of the following?

(Please tick the first box for past occurrence, second box for present condition.) ☑

General health

Past - Present

❒❒ General fatigue ❒❒ Poor Appetite ❒❒ Rashes ❒❒ Unexplained weight loss
❒❒ Fever ❒❒ Night sweats ❒❒ Spontaneous sweating ❒❒ Chills
❒❒ High blood pressure ❒❒ Low blood pressure ❒❒ Chest pains ❒❒ Irregular heart beat
❒❒ Cold hands ❒❒ Cold feet ❒❒ Swelling of hands ❒❒ Swelling of feet
❒❒ Insomnia ❒❒ Poor sleep ❒❒ Dream disturbed sleep ❒❒ Blurred vision
❒❒ Ulcerations ❒❒ Itching ❒❒ Eczema ❒❒ Loss of hair

Head, Neck and Lungs

❒❒ Migraine ❒❒ Flashing lights in eyes ❒❒ Nausea/vomiting ❒❒ Eye pain
❒❒ Headaches ❒❒ Earaches ❒❒ Ringing in ears ❒❒ Poor hearing
❒❒ Sinus or hay fever ❒❒ Nasal congestion ❒❒ Postnasal drip ❒❒ Recurrent ear infections
❒❒ Sore throat ❒❒ Dry throat ❒❒ Strong thirst ❒❒ Bitter taste in mouth
❒❒ Facial pain ❒❒ Teeth problems ❒❒ Grinding teeth ❒❒ Clicking jaw
❒❒ Recurrent cough ❒❒ Coughing blood ❒❒ Asthma ❒❒ Bronchitis

Musculoskeletal

❒❒ Neck pain ❒❒ Pain between shoulders ❒❒ Mid-back pain ❒❒ Lower back pain
❒❒ Shoulder pain ❒❒ Elbow pain ❒❒ Wrist pain ❒❒ Finger pain
❒❒ Hip pain ❒❒ Knee pain ❒❒ Leg pains ❒❒ Ankle pain

Gastrointestinal

❒❒ Nausea ❒❒ Vomiting ❒❒ Diarrhoea ❒❒ Constipation
❒❒ Gas (flatulence) ❒❒ Belching ❒❒ Indigestion ❒❒ Abdominal pains/cramps
❒❒ Blood in stools ❒❒ Black stools ❒❒ Rectal pain ❒❒ Haemorrhoids

Reproductive

❒❒ Pain on urination ❒❒ frequent urination ❒❒ Blood in urine ❒❒ Unable to hold urine
❒❒ Kidney stones ❒❒ Impotence ❒❒ Prostate problems ❒❒ Dribbling/burning urine
❒❒ Bed-wetting ❒❒ Testicular pains ❒❒ Sexual problems ❒❒ Pain on sexual activity
❒❒ Hot flushes ❒❒ Painful periods ❒❒ Irregular periods ❒❒ Heavy clotting on periods

Emotional Trauma

❒❒ Divorce ❒❒ Move house ❒❒ Move Country ❒❒ Cancer
❒❒ Loss of a close family member/friend ❒❒ Fallout with family or friend
❒❒ Other_____

Dietary - What would you eat on a "normal" day?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

I am: ❒ Vegetarian ❒ Vegan ❒ Eat everything ❒ Other_____

Which sentence describes you best?

❒ I am willing to do everything it takes to help my health, i.e. change my diet, exercise, take nutrition…etc.

❒ I am willing to change some things to improve my health, but I find change hard.

❒ I am not willing to change my diet, exercise take nutrition…etc.

Consent to Chiropractic Care and Natural Medicine

Changes to the law now require all practitioners who adjust the spine to warn clients of material risks.

In extremely rare circumstances, chiropractic care of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 5,850,000 neck adjustments). While this has never occurred in this office, we are still required to warn you. If any adjustments are required, you will be tested beforehand, as has always been our practice (i.e. check for dizziness, referred pain etc.)

Other than slight risks including strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000), chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with spine related problems than medication and many other alternatives.

When performed by a registered Chiropractor, manipulation is an effective and safe method of treatment for many conditions. However, you must be informed about the rare risks involved as with all health care procedures.

These risks include: muscle and joint soreness or strains, nausea, vomiting, stomach upsets, infections, rashes, dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation of an underlying condition.

Careful attention to the questions below will help us to ensure that these risks are minimised and the appropriate treatment is provided.

Health Screening: Have you ever been diagnosed, or experienced any of the following problems or conditions?

❒ Cancer	❒ Pins & needles or numbness	❒ Heart disease/infection	❒ HIV or AIDS
❒ Are you pregnant?	❒ Arthritis	❒ Anaemia	❒ Required a heart pacemaker
❒ Pain waking you at night	❒ Hepatitis	❒ Blood disorders	❒ High Blood Pressure
❒ Epilepsy	❒ Collapsed lung	❒ Diabetes	❒ Dizziness
❒ Stroke	❒ Blood clotting problems	❒ Pain on coughing	❒ History of fainting
❒ Knocked unconscious	❒ Pain with straining	❒ Pain on sneezing	❒ Any other serious illness

If yes, then please provide details:

_____

_____

If you have any further questions, please ask your practitioner during your consultation. You have the opportunity to discuss your proposed care with your practitioner and are encouraged to ask questions about the nature, extent and purpose of care that you need, and given time to make a decision giving consent for the care to proceed.

I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed and I do not expect the practitioner to be able to anticipate all potential risks and possible complications associated with my proposed care.

I hereby acknowledge my consent to the performance of Chiropractic care, Massage and Natural Medicine by my Practitioner.

_____ _____

Patient's Signature
(Parent/Guardian to sign if under 18)

Chiropractor's Signature

_____ _____

Date

Date