shambrook
FAMILY CHIROPRACTIC

New Patient Questionnaire

YOUR DETAILS

Date: ____ / _____ / _____

NAME: Title _____ First Name _____ Surname _____

GENDER: ☐ Male ☐ Female Date of Birth: ____ / _____ / _____

ADDRESS: _____

Suburb _____ State _____ Postcode _____

POSTAL ADDRESS:
(If different from above) _____

Suburb _____ State _____ Postcode _____

TEL NUMBERS: Home _____ Mobile _____ Work _____

PREFERRED TEL: ☐ Home ☐ Mobile ☐ Work

EMAIL ADDRESS: _____

GP'S NAME AND PRACTICE: _____

ARE YOU A MEMBER OF A PRIVATE HEALTH FUND?

☐ No ☐ Yes - Fund Name: _____

IS YOUR CHIROPRACTIC CARE COVERED BY VETERAN AFFAIRS OR MEDICARE ENHANCED PRIMARY CARE (EPC)?

☐ No ☐ Yes (Please present your referral form to us)

OCCUPATION: _____

IF RETIRED OR UNEMPLOYED, YOUR PREVIOUS OCCUPATION: _____

FAMILY MEMBERS:

Name(s) of other Family members (s)	Age(s) of other Family member (s)
_____	_____
_____	_____
_____	_____
_____	_____

WE APPRECIATE REFERRALS. HOW DID YOU FIND OUT ABOUT OUR CLINIC?

☐ Family member ☐ Another Health Professional

☐ Our Signage

☐ Friend, please specify: _____

☐ Other, please specify: _____

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PRESENT STATE OF HEALTH

Our focus will be on finding the underlying cause(s) of your ache, pain or condition and help your body heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from a body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major symptom/problem:_____

Pain / Problem started on:_____ triggered by: _____

Have you had previous episodes of this problem?

☐ No ☐ Yes Number of Times: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is the pain referring to other areas of your body? ☐ No ☐ Yes: Where? _____

Is condition getting worse? ☐ No ☐ Yes

What brings on your condition or makes it worse? _____

What relieves your condition or makes it feel better? _____

Is this symptom/condition interfering with: ☐ Work ☐ Sleep ☐ Routine

☐ Other (please specify) _____

Have you seen other Doctors/Practitioners for this condition? ☐ No ☐ Yes

If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other

Please list any home remedies employed: _____

DAILY ACTIVITIES

Do your daily activities involve: ☐ Sitting ☐ Walking ☐ Heavy Lifting ☐ Repetitive Tasks

☐ Writing ☐ Driving ☐ Manual work ☐ Standing

☐ Phone Use ☐ Desk Work ☐ Emotional Stress

Do you play a musical instrument? ☐ No ☐ Yes

Do you read for prolonged periods? ☐ No ☐ Yes

Do you wear: ☐ Dentures / A Plate ☐ Glasses or Bifocals ☐ Contact Lenses

Sleeping posture ☐ Side ☐ Back ☐ Stomach

Sports you play / used to play _____ ☐ Currently play ☐ Used to play

_____ ☐ Currently play ☐ Used to play

_____ ☐ Currently play ☐ Used to play

_____ ☐ Currently play ☐ Used to play

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DAILY ACTIVITIES CONT...

Are you trying to: ☐ Gain Weight ☐ Lose Weight ☐ Neither

Do you exercise? ☐ Daily - Weekly ☐ Occasionally ☐ Never

Do you smoke? ☐ No ☐ Yes: _____per day

Do you sleep well? ☐ No ☐ Yes. Approx. hours of sleep per night_____

Do you use drugs? ☐ Never ☐ Occasionally ☐ Often

With regard to any drugs you currently or have recently used, please list:

Drug/medication Names	Dosage	Reasons for use

Have you received chiropractic care before? ☐ No ☐ Yes

If yes, when was your last visit? _____

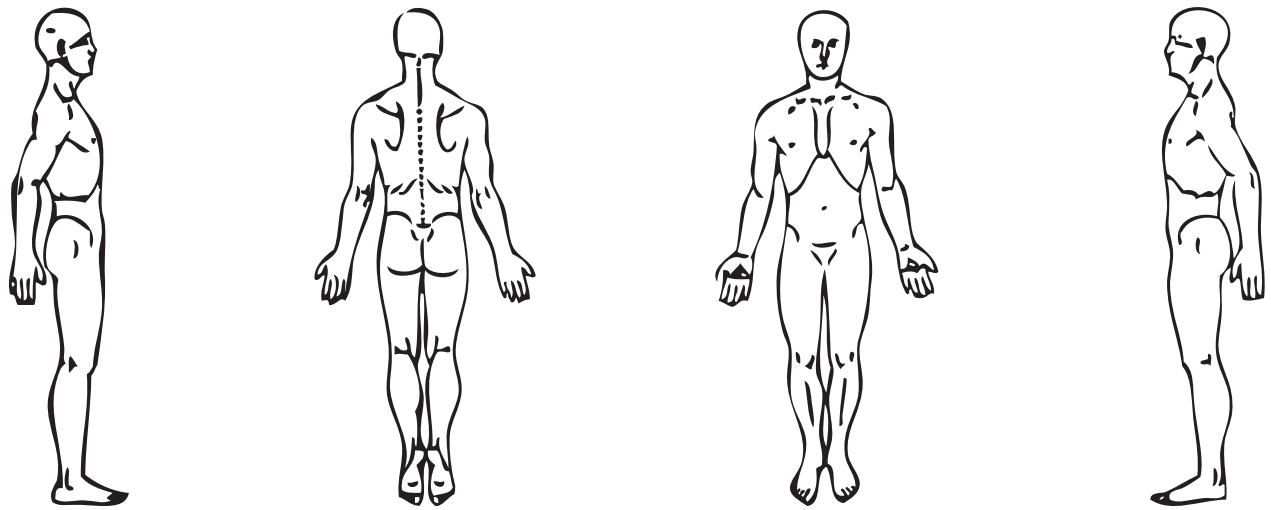
Were you pleased with the service provided? _____

Have you ever had any spinal X-rays taken? ☐ No ☐ Yes. When?_____

Which spinal areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -

R L R R L L



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PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between Chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Patient's Signature: _____

Date: _____

PATIENT INFORMATION

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatment of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. (Current literature states this to be approximately 1 in 1-2 million according to D. Chapman-Smith, seminar 2002 and approximately 1 in 5.85 million neck manipulations according to Haldeman, et al, Spine vol. 24-8 1999).

Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000).

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993).

Please note that this consent does not waiver your Common Law Rights, rather it is merely for you to acknowledge that you have been informed of the known risks.

If you have any questions related to the treatment you are about to receive or possible alternative approaches, please speak to the Chiropractor.

I have discussed the above information with the chiropractor and give my consent to treatment.

Patient's Signature: _____ Print Name: _____

Chiropractor's Signature: _____ Date: _____

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