CONFIDENTIAL HEALTH QUESTIONNAIRE

Welcome to Kensington Chiropractic. Please complete the following questionnaire in as much detail as possible.

PERSONAL DETAILS

Ms/ Mrs/ Miss/Mr/Mast/Dr _____
(Please circle) *Surname* *Given Name(s)* *Preferred name*

D.O.B.:_____ Age: _____ Guardian name if required_____

Marital Status_____ Partner's name_____ Number of children_____

Postal Address: _____
Unit/Apt No. *Street No.* *Street Name* *Suburb* *State* *Post Code*

Email address:_____@_____ Occupation: _____

Telephone Numbers Mobile: _____ Home: _____Work: _____

Name of emergency Contact: _____ Telephone Number: _____

Do you have private health insurance? ☐ Yes ☐ No Name of Insurance_____ Member No_____ Id No___

Are you a concession card holder? ☐ Yes ☐ No Please specify type & Exp. Date: _____

How did you find out about us?

☐ Patient/Family/Friend - Name: _____ ☐ Google / Internet / Web

☐ Medical professional – Type & Name _____ ☐ Other: _____

HEALTH QUESTIONNAIRE

Have you had any previous chiropractic care? ☐ Yes ☐ No If yes, reason_____

_____

Name of previous Chiropractor: _____ Date of last visit: _____

In your own words, please describe your chief complaint and when you first noticed the problem: _____

_____

_____

What seems to make the problem better? _____

_____

What seems to make the problem worse? _____

_____

When does it seem to be at its worst? _____

What type of pain is it? (Please tick☑)

☐ Sharp ☐ Stabbing ☐ Achy ☐ Burning ☐ Dull ☐ Diffuse ☐ Localized

Does the pain radiate to other areas of your body? ☐ Yes ☐ No If so where? _____

Has this problem been treated before and if yes, how? _____

_____

Do you have any other health complaints? _____

Who is your normal Medical doctor? _____

Please list any medication you are taking (or attach list) : _____

_____

_____

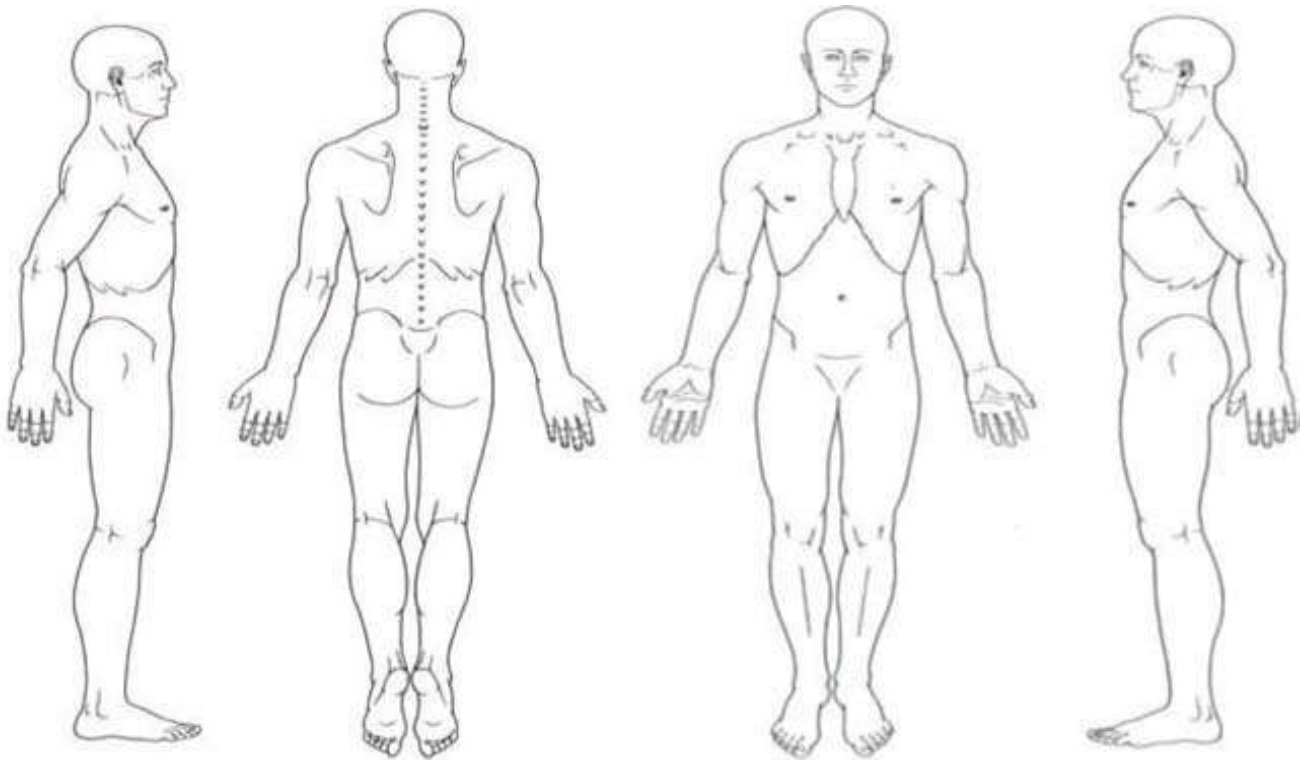
kcfh@bigpond.net.au Unit 3/95 Canning Highway, South Perth WA 6151 Phone: 08 9368 0100 Fax: 08 9368 0100

SYMPTOM DIAGRAM

Please mark the areas on your body where you feel the described sensations.

Please use the appropriate symbol and include **all** affected areas

Aching **** Numbness **+++** Pins & Needles **ooo** Stabbing **sss**



Using the scale provided below, rate the pain you are experiencing now:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

What are your treatment goals? _____

_____

PHYSICAL HISTORY

Musculoskeletal system

- ☐ Neck problems
- ☐ Upper back problems
- ☐ Lower back problems
- ☐ Shoulder problems
- ☐ Elbow/wrist problems
- ☐ Wrist pain/lower arm pain
- ☐ Knee problems
- ☐ Ankle /foot problems
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Concussion

Female

- ☐ Premenstrual syndrome
- ☐ Pregnancy

Nervous system

- ☐ Numbness
- ☐ Weakness
- ☐ Headaches/Migraines
- ☐ Dizziness
- ☐ Fainting

Gastrointestinal system

- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Weight loss/gain

Eyes, Ears, Nose & Throat

- ☐ Eye problems
- ☐ Ear ringing/Hearing loss
- ☐ Allergies

Cardio-Vascular-Respiratory

- ☐ Heart disease
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm/blood
- ☐ Lung problems
- ☐ Diabetes
- ☐ Hypoglycaemia
- ☐ Asthma
- ☐ Stroke

Other

- ☐ Confusion
- ☐ Depression
- ☐ Forgetfulness
- ☐ Cancer
- ☐ Psoriasis
- ☐ Epilepsy
- ☐ Recent change to bladder function
- ☐ Recent change to bowel function
- ☐ Any other not mentioned here

Please list below:

_____

_____

_____

_____

PAST HEALTH HISTORY

Previous hospitalisation or operations

Reason_____ Date_____
Reason_____ Date_____
Reason_____ Date_____

Major falls or accidents _____ Date_____
_____ Date_____
_____ Date_____

Is this a motor vehicle accident injury? ☐ Yes ☐ No Have you lodged a claim? ☐ Yes ☐ No
If yes, when was the accident date? _____ Claim Number? _____

Is this a work related injury? ☐ Yes ☐ No Have you lodged a claim? ☐ Yes ☐ No
If yes, when was the accident date? _____ Claim Number? _____

Name of Insurance company _____

OFFICE POLICY & PATIENT DECLARATION

Please read this policy carefully, sign and date the policy and patient declaration before returning to reception.
Should you have any questions or concerns, please notify the reception staff.

We appreciate any notice of your unavailability to attend an appointment or if you are running late so that we can make the appointment available to other patients.
We require a minimum of four (4) hours advanced notice to reschedule or cancel a chiropractic appointment, so that this time can be allotted to patients on our waiting list. Late cancellations and missed appointment may incur a fee of $30.
Please note that arriving late (>10 minutes) for your appointment may result in forfeiture of your appointment time, and you may not be able to be seen. We will however do our best to fit you in or reschedule your appointment to another time.

Please note you are responsible for your appointment. SMS/text message reminders are sent as a courtesy.

If you have a NEW INJURY, you must inform the clinic when booking the appointment, so that the chiropractor may have the time necessary to properly evaluate the injury. Please note that this may necessitate an extended consultation and a change of time for the visit.

What you can expect from us:
We will do our utmost to run on time. We will do our best to accommodate emergencies and appreciate your patience and understanding if we are running behind due to one of these situations.
Please note that patients are seen based on appointment time, not arrival time.
If we are running late and you are unable to wait, please let the front desk know and we will gladly reschedule your appointment.

These policies allow us to better manage our practitioners' diary, encouraging shorter wait times and allowing us to more easily accommodate your schedule. We appreciate your understanding in its implementation.

I hereby declare that:

- I understand that payment is required at the time services are rendered unless alternate arrangements have been made with the practitioner prior to the appointment. I acknowledge that if for some reason payment is not made, then I am also responsible for any additional cost incurred in recouping these fees;
- I understand if an insurance claim is denied, then I am responsible for all incurred fees;
- I have read this Office Policy and I understand these obligations as a patient of Kensington Chiropractic;
- The information I have provided in this questionnaire is correct to the best of my knowledge.

Name & signature_____ **Date:** _____
(Patient, Parent or Guardian)

PATIENT INFORMATION & CONSENT

PLEASE READ THE FOLLOWING BEFORE SEEING YOUR CHIROPRACTOR

There are some risks that may be associated with Chiropractic treatment. In particular, you should note:

a. While rare, some patients may experience short term aggravation of symptoms, or muscle and ligament strain or sprains following treatment. These are generally self-limiting in nature (last 1-2 days). Although uncommon, rib fractures have also been known to occur following certain manual adjustments.

b. There has been widespread concern that chiropractic adjustments/manipulations may cause stroke in the form of a tear of the vertebrobasilar artery (VBA). The most recent research regarding this phenomenon indicates that:

i. These types of stroke are extremely rare, and can occur in younger populations (approximately 1 in 5.85 million).[1]
ii. These types of strokes may cause serious neurological impairment and may result in death or paralysis.
iii. Research and scientific evidence does not establish a cause/effect relationship between Chiropractic treatment and the occurrence of stroke. The risk of having a VBA stroke is the same after seeing a chiropractor as a primary health care provider. Research indicates that adjustments/manipulations likely do not cause these strokes. Rather, people who are experiencing this type of stroke visit health care providers, including chiropractors.[3,4]
iv. There is no reliable to test to determine if you are experiencing this phenomenon.[4]

c. There have been rare reported cases of disc injuries following cervical (neck) (less than 1 in 139,000) and lumbar (low back) (1 in 62,000) spinal adjustments. No scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments/manipulations or other Chiropractic treatment.[2]
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[5,6].
Adverse reactions can often be the result of an underlying health condition or predisposed by other health factors. Thoroughness when completing your patient health questionnaire is very important to determine if you are at any increased risk of adverse reaction.

☐ I understand that the practitioner will endeavour to minimize the risks of such events and reactions.

☐ I acknowledge that I am aware of the potential risk and I appreciate that like all health care modalities, results are not guaranteed.

☐ I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

☐ I hereby acknowledge my consent to the treatment and I understand that I can withdraw consent at any time.

☐ I understand there may be a considerable degree of variation in individual patient response.

☐ I understand that the recommendations for care are important factors in determining the likely of success of my care.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my Chiropractor the nature and purpose of Chiropractic treatment in general (including spinal adjustment), the treatment options and recommendations for my conditions, and the contents of this consent.

Please do not sign this consent form until you have discussed this with your chiropractor.

Patient's Signature: _____ Print name: _____

Chiropractor's Signature: _____ Date: _____

REFERENCES
1 Halderman et al. Neck Manipulations, Spine Journal, vol 24-8, 1999
2 Dvorak Study in Principles and Practise of Chiropractic, Halderman. 2nd Edition
3 Cassidy et al. Spine. 2008. Risk of Vertebrobasilar Stroke and Chiropractic Care: Results of a Population-based Case-control and Case-crossover Study.
4 Souza. Differential Diagnosis and Management for the Chiropractor, Fourth Edition. 2009.
5 Dabbs & Lauretti. A Risk Assessment of Cervical Manipulation, JMPT, 1995.
6 Manga Report, Ontario Ministry of Health, 1993.

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