FOR OFFICE USE ONLY

CAP PP REP HRA
CON GR LET EN
SCANNED

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

Suburb _____ PostCode _____

Home Phone _____

Mobile Phone _____

Email _____

Sex ❑ M ❑ F Age _____ D.o.b. _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Private Health Fund: _____

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

How will you be paying today? (circle)
Cash / Cheque / Credit Card / Eftpos / Health Fund

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

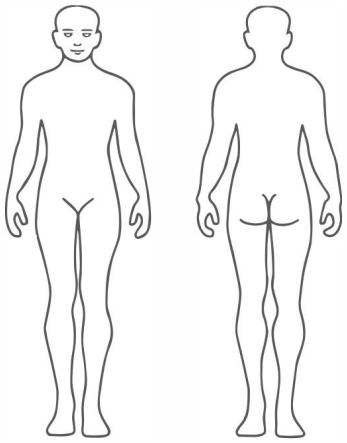
0 = NO SYMPTOMS; 10 = INTENSE SYMPTOMS

Please mark areas to the right where you have pain or other symptoms:

Pain : /////

Numbness: XXXX

Pins & Needles : +++++



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp
❑ Tingling ❑ Shooting
❑ Stiffness ❑ Burning
❑ Dull ❑ Throbbing
❑ Aching ❑ Stabbing
❑ Cramping ❑ Swelling
❑ Nagging ❑ Other _____

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITTED; 10 = VERY COMMITTED

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE NOTE CHIROPRACTIC CARE IS NOT COVERED UNDER MEDICARE & MASSAGE THERAPY IS NOT COVERED BY SOME HEALTH PROVIDERS

I understand that this information will be used by the Chiropractor/Massage Therapist to help determine appropriate & healthful Chiropractic/Massage treatment.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

SIGNATURE: _____ DATE: _____

CACTUS CHIROPRACTIC
Lifestyle Centre
1 Sesame Court Slacks Creek
Tel: 3808 8040

SHA Questionnaire

1) On average, over the past 30 days I have used medication to treat HEADACHE, PAIN, OR INFLAMMATION the following number of DAYS per WEEK:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7

2) I am currently using medication to treat PAIN, INFLAMMATION, or HEADACHE:

◯ Yes ◯ No

3) On average, over the past 30 days has PAIN limited your ability to READ?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

4) On average, over the past 30 days has PAIN limited your ability to CONCENTRATE?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

5) On average, over the past 30 days has PAIN limited your ability to SIT?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

6) On average, over the past 30 days has PAIN limited your ability to SLEEP

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

7) On average, over the past 30 days has PAIN limited your ability to ENGAGE IN SOCIAL INTERACTION?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

8) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to ENGAGE IN SOCIAL INTERACTION?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

9) On average, over the past 30 days has PAIN limited your ability to conduct PERSONAL GROOMING/LOOK AFTER YOURSELF?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

10) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to conduct PERSONAL GROOMING/LOOK AFTER YOURSELF?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

11) On average, over the past 30 days has PAIN limited your ability to LIFT HEAVY OBJECTS?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

12) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to LIFT HEAVY OBJECTS?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

13) On average, over the past 30 days has PAIN limited your ability to STAND?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

14) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to STAND?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

15) On average, over the past 30 days has PAIN limited your ability to WORK/ATTEND SCHOOL?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

16) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to WORK/ATTEND SCHOOL?

◯ Never ◯ Seldom ◯ Sometimes ◯ Often ◯ Always

17) On average, over the past 30 days has PAIN limited your ability to OPERATE A VEHICLE safely and comfortably?

○ Never ○ Seldom ○ Sometimes ○ Often ○ Always

18) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to OPERATE A VEHICLE safely (eg. perform shoulder check etc.)?

○ Never ○ Seldom ○ Sometimes ○ Often ○ Always

19) On average, over the past 30 days has PAIN limited your ability to ENGAGE IN RECREATIONAL ACTIVITIES?

○ Never ○ Seldom ○ Sometimes ○ Often ○ Always

20) On average, over the past 30 days has LACK OF FUNCTIONAL ABILITY (loss of mobility, balance, strength) limited your ability to ENGAGE IN RECREATIONAL ACTIVITIES?

○ Never ○ Seldom ○ Sometimes ○ Often ○ Always

21) On average, over the past 30 days I would rate my average overall DAILY PHYSICAL COMFORT level as:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Very Low Very High

22) On average, over the past 30 days I would rate my average overall FUNCTIONAL ABILITY (mobility, balance, strength) to perform physical activities of daily living as:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Very Low Very High

23) I would rate my current overall PHYSICAL COMFORT level as:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Very Low Very High

24) I would rate my current overall FUNCTIONAL ABILITY (mobility, balance, strength) to perform physical activities of daily living as:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Very Low Very High

25) On average, over the past 30 days, I have supplemented with a MINIMUM of 1000 IUs of VITAMIN D3 per 18 kilograms/40 pounds of body weight the following number of DAYS per WEEK:

○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7

26) On average, over the past 30 days, I have supplemented with a MINIMUM of 450 milligrams of EPA and 300 milligrams of DHA per 18 kilograms/40 pounds of body weight from an UNCONCENTRATED, NATURAL TRIGLYCERIDE, FULL FATTY ACID COMPLEMENT OMEGA-3 FISH OIL the following number of DAYS per WEEK (If you don't supplement with Omega-3 at all, indicate your score as 0):

○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7

27) On average, over the past 30 days, I have performed at least 30 minutes of AEROBIC exercise (e.g. brisk walking, hiking, biking, jogging, swimming, etc.) the following number of DAYS per WEEK.

○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7

28) On average, over the past 30 days, I have performed SPINAL CONDITIONING exercises (exercises to strengthen spinal postural muscles) and SPINAL HYGIENE exercises (exercises to improve range of motion and posture) the following number of DAYS per WEEK:

○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7

29) On average, over the past 30 days, I have performed RESISTANCE exercise sessions the following number of DAYS per WEEK:

○ ○ ○ ○
0 1 2 3+

30) On average, over the past 30 days, I typically SIT at work/school, commuting, and during my leisure time for the following number of combined HOURS per DAY (only count the hour if you do NOT get up and take a spinal mobility break in that hour):

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10+

31) During my lifetime, I have suffered the following number of SIGNIFICANT SPINAL TRAUMAS or INJURIES (from falls, accidents, work or sport activities, etc.) that have resulted in neck or back pain,and/or the need to limit activities for more than one week and for which I did not receive at least 12 visits of acute chiropractic care in the first 6 weeks following the injury/trauma:

○ ○ ○ ○ ○
0 1 2 3 4+

32) I have had a chiropractic spinal health exam within the past 12 months.

○ Yes ○ No

33) I have been regularly following a professionally prescribed spinal health and fitness plan for the past number of months:

○ ○ ○ ○ ○
0 3 6 9 12

34) On average, over the past 30 days, I would rate my overall level of PSYCHOLOGICAL/EMOTIONAL STRESS as:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Very Low Very High

35) On average, over the past 30 days, I have consumed/used TOBACCO PRODUCTS (cigarettes, chewing tobacco, pipes, cigars) the following number of times per DAY:

○ ○ ○ ○ ○
0 1 2 3 4+

Height _____ cms

Weight _____ kgs