Confidential Patient Case History

DEAR PATIENT: Please complete this questionnaire.
Your answers will help us to determine if Chiropractic can help you.

Name…… Today's Date……/……../…….
Address…… Suburb…… Post Code……
Phone: Home…….…… Work…… Mobile……...……
Email: …….. D.O.B……/……../……
Marital Status…… Children? How many? ……..…….
Occupation…… How did you find out about us? ……
Do you have Private Health Cover? Yes / No Which fund? ……

Please tick if you have suffered from any of the following symptoms, whether past or present:

Past	Present		Past	Present		Past	Present	
☐	☐	Chronic/ frequent headaches	☐	☐	Pain in ribs	☐	☐	Chronic cough/Asthma
☐	☐	Pain in head	☐	☐	Low back pain/stiffness	☐	☐	Frequent nausea/vomiting
☐	☐	Soreness in neck	☐	☐	Low back weakness	☐	☐	Digestive malfunction
☐	☐	Dizziness	☐	☐	Hip pain/stiffness	☐	☐	Allergies
☐	☐	Shoulder pain	☐	☐	Buttock pain	☐	☐	Bed wetting
☐	☐	Arm pain	☐	☐	Leg pain/cramps	☐	☐	Urinary problems
☐	☐	Loss of arm power	☐	☐	Frequent pins & needles in legs or feet	☐	☐	Menstrual disorders
☐	☐	Shoulder pain/stiffness	☐	☐	Knee pain/stiffness	☐	☐	Loss of potency
☐	☐	Elbow pain	☐	☐	Ankle pain/stiffness	☐	☐	Other sexual disorders
☐	☐	Wrist or hand pain	☐	☐	Foot pain/stiffness	☐	☐	Chronic fatigue
☐	☐	Pins & needles in hands	☐	☐	Sleeping problems	☐	☐	Other……...
☐	☐	Loss of grip	☐	☐	Insomnia	……		
☐	☐	Mid back pain/tension	☐	☐	Sinus trouble	……		

Present Symptoms

What are your present symptoms? ……
Original onset date? …… Recent onset date? ……..
Caused by? ……..
Previous treatment? ……..……Result? ……
Have you had any X-rays ☐ CT Scans ☐ MRIs ☐ recently? Location? .....
Any family history of this problem? Yes / No
Are you symptoms aggravated by, or related to, your work? Yes / No
What medications are you taking? ……
Have you seen a chiropractor before? Yes / No
Do you sleep on your **Side / Back / Stomach**? Do you have a **Soft / Medium / Hard** mattress?
How many pillows do you use? ……
Is there any possibility that you might be pregnant? Yes / No

FINANCIAL POLICY: ***We would appreciate payment at time of consultation.***

Patient Information

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risk. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke-like symptoms (approx.. 1 in 5.85 million neck manipulations. 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 low back (1 in 62,000) (Dvorak study principles and Practice of Chiropractic, Haldeman, 2nd Ed.).

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).

If you have any questions related to the treatment you are about to receive, 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** ……/……/……

DO YOU AUTHORISE TAMAR CHIROPRACTIC TO SEND YOU A WELCOME EMAIL?

☐ ***YES***
☐ ***NO***

DO YOU AUTHORISE ANY PERSON TO MAKE OR CHANGE APPOINTMENTS ON YOUR BEHALF?

Nominated Person: …… **Relationship:** ……

Sign: ……..

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