Caringbah Spinal Care

AQ 1

Personal Details

CONFIDENTIAL

PLEASE USE A BLACK PEN ONLY AS OUR SCANNER WILL ONLY PICK UP BLACK PEN

NAME: Dr/Mr/Mrs/Ms_____

ADDRESS: _____

_____ POSTCODE: _____

PHONE HOME: _____ PHONE WORK: _____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDATE: _____ AGE:_____ OCCUPATION: _____

PARTNER'S NAME: _____ NO. OF CHILDREN: _____

What Health fund do you belong to? _____

Are you covered for chiropractic care (we need to know this as some health funds require specific item numbers)? _____

Is this related to a Workers Compensation [ ] or Third Party Claim [ ] ? [ ] No

Who is your regular doctor (General Practitioner)? _____

We are grateful that our practice grows by referral. Who may we thank for referring you?

_____

Have you ever seen a Chiropractor before?

Yes [ ] If YES which type? [ ] Condition based Chiropractor- Neck Pain/ Back Pain

[ ] Wellness/Lifestyle/Nerve System Chiropractor [ ] Unsure?

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating your spine and neurological function.

Major Complaint

What is your main problem? _____

When and how did it start? _____

Was there any of the following prior to or during the onset? (Please circle)

Illness / infection/ Trauma/ Other significant event

Have you had this or similar conditions in the past? Yes / No If Yes When? _____

Are your symptoms worse at night? Yes / No _____

Is your problem getting worse? Yes / No _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

Are your symptoms worse at night or any specific time of the day? _____

_____

Do you have any pain traveling down your arms or legs? Yes / No If yes, describe _____

_____

Does your current problem involve any of the following? If Yes, where?

Tingling in either arm or leg Yes / No _____
Numbness in either arm or leg Yes / No _____
Weakness in either arm or leg Yes / No _____
'Weird' sensations in either arm or leg Yes / No _____

Have you had any other treatment for your current problem? Yes / No _____

_____

Please **circle** where applicable:

Sleep position **Stomach/ Back/ Side** Number of pillows used?: _____ Age of mattress?: _____

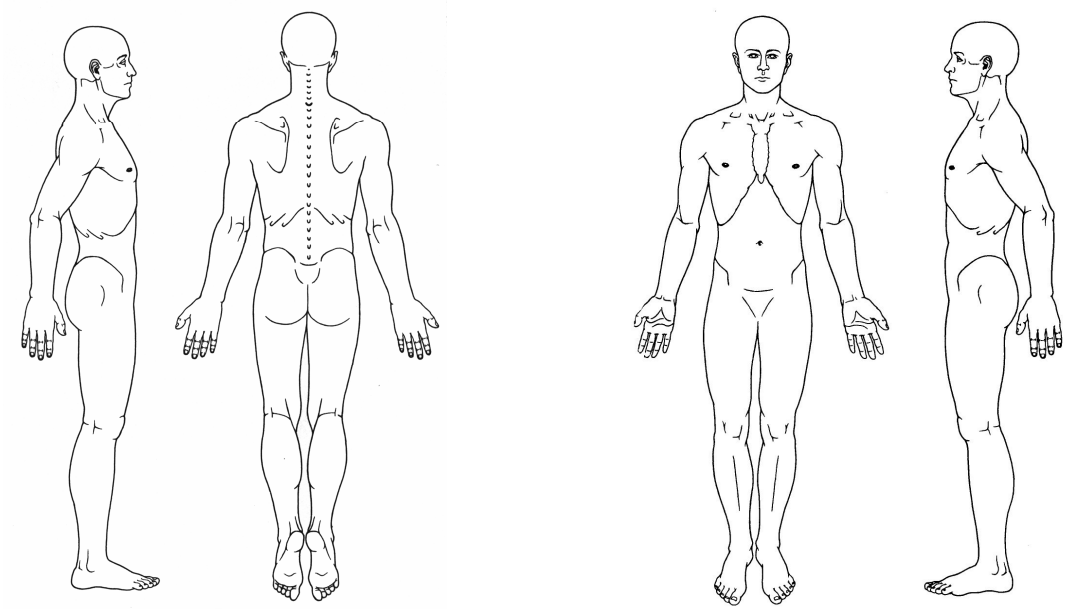
Do you use any of the following in your shoes? **Orthotics/ Heel Lift/ Arch Supports**

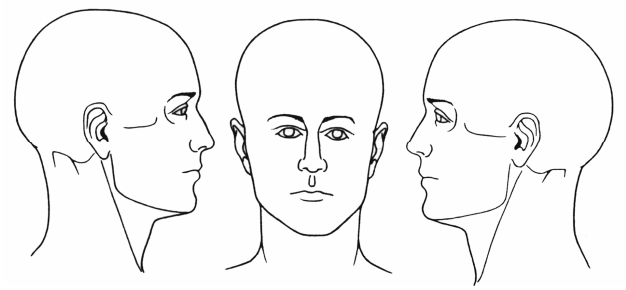
Please list any sports, hobbies or activities you participate in regularly: _____

_____

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.





Medical History & General Health

Please circle Yes/No where applicable: Describe:

Did you / Do you smoke? Yes / No _____

Did you / Do you drink alcohol? Yes / No _____

Did / Do you take recreational drugs? Yes / No _____

Do you think you have a healthy diet? Yes / No _____

Do you take vitamin supplements? Yes / No _____

Do you exercise regularly? Yes / No _____

Have you had any form of surgery? Yes / No _____

_____

Are you currently taking ***any*** form of medication? Yes / No If yes list all of them _____

_____

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No

_____

Have you had any broken bones? Yes / No If yes, which ones and how? _____

_____

Have you had any car accidents (no matter how trivial)? Yes / No If yes, when and describe

_____

Have you had any falls or sports injuries? Yes / No If yes, when and describe _____

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No

_____

Do you suffer from fatigue?	Yes / No	_____
Does your heart ever seem to miss a beat?	Yes / No	_____
Do you suffer with shortness of breath on exertion?	Yes / No	_____
Are you troubled by pain or tightness in your chest on exertion?	Yes / No	_____
If yes: Is it relieved by resting?	Yes / No	_____
Do you suffer with a cramp-like pain in either leg when walking?	Yes / No	_____
If yes: Do you have to stop or slow down to relieve it?	Yes / No	_____
Are you troubled with a frequent or persistent cough?	Yes / No	_____
Do you have allergy problems?	Yes / No	_____
Are you troubled with pain or aching in your stomach?	Yes / No	_____
If yes: Is it relieved by eating or by drinking milk?	Yes /No	_____
Have you had any persistent change in your appetite during the last three months?	Yes / No	_____
Has your weight changed more than ten pounds (4 Kg) in the last year?	Yes / No	_____
Are you troubled with frequent loose bowel movements?	Yes / No	_____
Are you troubled with constipation?	Yes / No	_____
Have you noticed any blood or mucus in your bowel movements?	Yes / No	_____
Are you troubled with haemorrhoids?	Yes / No	_____
Do you have any pain or difficulty with passing water?	Yes / No	_____

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Are you passing water more frequently lately?	Yes / No	_____
Do you get pain in any of your joints?	Yes / No	_____
If yes, is it worse in the night?	Yes / No	_____
Do your joints ever swell?	Yes / No	_____
Do you wake up with stiffness or aching in your joints or muscles?	Yes / No	_____
Have you or your partner noticed any change in your personality?	Yes / No	_____
Do you have difficulty concentrating?	Yes / No	_____
Do you have any problems with memory?	Yes / No	_____
Do you have any problems with hearing (including ringing in the ears)?	Yes / No	_____
Do you have problems with smell or taste?	Yes / No	_____
Have you noticed any problems with choosing words or hand writing?	Yes / No	_____
Did you / Do you have occupational stress?	Yes / No	_____
Does stress seem to make your main problem worse?	Yes / No	_____
Are you easily depressed?	Yes / No	_____
Do you suffer from anxiety?	Yes / No	_____
Do you have poor sleep?	Yes / No	_____
Do you grind or clench your teeth?	Yes / No	_____
Are you often troubled by headaches?	Yes / No	_____
If yes: Are they accompanied by sickness or other symptoms?	Yes / No	_____
Do you have any problems with your vision?	Yes / No	_____
Does one eye water more than the other?	Yes / No	_____

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Do you get cold hands or feet?	Yes / No	_____
Do you have varicose veins?	Yes / No	_____
Have you any lumps, cysts, or unusual swellings anywhere on your body?	Yes / No	_____
Do you get twitching or cramping anywhere?	Yes / No	_____
Do you have any problems with sweating?	Yes / No	_____
Do you have poor balance?	Yes / No	_____
Did you / Do you suffer vertigo?	Yes / No	_____
Do you get car/motion sickness?	Yes / No	_____
Are you subject to blackout, dizzy spells, or faints?	Yes / No	_____
Do you have a tendency for clumsiness?	Yes / No	_____

Caringbah Spinal Care specialises in problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please (circle) and complete the following:

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

_____
(Signature)

_____
(Print Name)

_____
(Date)