WELCOME TO HAPPY SPINE

We would like to thank you for choosing Happy Spine and acknowledge your commitment to improving your health & wellbeing.

At Happy Spine, we are concerned with correcting the health of your spine, posture & nervous system, to not only eliminate your symptoms, but to improve your overall health, wellness and prevent dis-ease now and in the future.

First Visit – How good or bad is your problem? 60-75 minute

Includes: Chiropractic exams, consultation, x-rays (if clinically necessary), report of findings & recommendations for care. The fee is $199 and is payable on the day.

Additional Options:
After the initial assessment, we will know if Chiropractic care is right for you. If so we can start care straight away. Chiropractic care involves an adjustment to your spine aiming to bring it back into alignment for greater health and well being. The cost is $75 or $52 on ACC per adjustment.

Below is your personal health history form. Please complete the form to the best of your ability. The information will be used by the Chiropractor to see how best they can help you.

Name:	E-mail:
Address: Suburb: Postcode:	Would like to receive our monthly newsletter? ☐ YES ☐ NO
Home Phone: Mobile:	Are you happy to receive txt reminders from us? ☐ Y ☐ N
DOB: Age:	Occupation:
*Marital Status: *Partner's Name: *Children's Ages:	*How did you hear of Happy Spine?

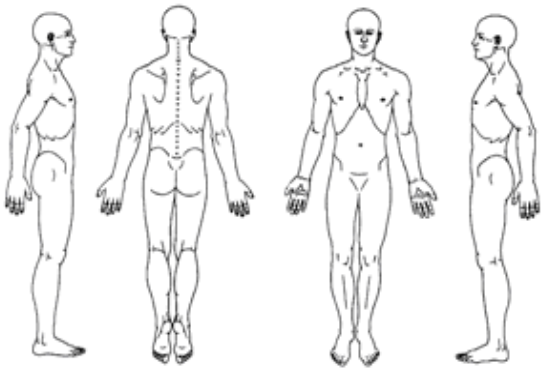
*Optional

What is your main objective?

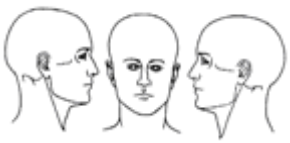
☐ Spinal health check ☐ Quick fix ☐ Correct the cause ☐ Restore health & stay healthy

Current Symptoms

Right Back Front Left



On the body map to the left, please indicate any current problem areas. Use the following to identify:
O = Pain
X = Pins & needles/numbness
# = Abnormal sensation (burning/swelling etc.)



Please use the following 4 boxes to list your main health concerns/symptoms. (if you only have 1 concern just fill in 1)

Concerns / Symptoms	**Rate the severity** 0 = no pain 10 = worst imaginable	**When did this start?** (days, weeks, months, year, 5 years etc.)	**If you had this condition before? When?**	**Description of pain** (dull, achy, sharp, stabbing)	**% of the time pain is present**
1.					
2.					
3.					

Current symptoms continued:

Is your main concern getting worse? ☐ Yes ☐ No ☐ Comes and Goes ☐ Constant

What do you think caused this pain? _____

Have you had this or similar condition(s) in the past?
Describe: _____

Other Doctors / Practitioners you have seen for this condition(s):

_____

Have you ever had x-rays taken? ☐ No ☐ Yes, when: _____ Body Part: _____

Is this problem interfering with any of the following?

☐ Work ☐ Sleep ☐ Daily routine ☐ Sports Exercise ☐ Other (please explain) _____

Please rate any health concerns you have below out of 10. 10 is worst pain imaginable, 0 no pain at all

Neck Pain	___/10	Fatigue/low energy levels	___/10
Mid back pain	___/10	Poor concentration	___/10
Lower back pain	___/10	Nervousness/Depression	___/10
Shoulder pain	___/10	Allergies/sinus	___/10
Hip Pain	___/10	Asthma/bronchitis	___/10
Numbness and tingling in legs	___/10	Indigestion/heart burn	___/10
Numbness and tingling in arms	___/10	Bowel or bladder problems	___/10
Poor Posture	___/10	Constipation/diarrhea	___/10
Migraines	___/10	Menstrual problems	___/10
Headaches	___/10	Night sweats	___/10
Difficulty sleeping	___/10	Unexplained weight loss	___/10
Irritable/moody	___/10	Infertility	___/10
Dizziness/ringing in the ears	___/10	High/Low blood pressure	___/10

Key Lifestyle Factors

Hours worked per week: _____ how long have you been in your current job type? _____

Work Activities (Please circle): Sitting Walking Lifting Other:_____

Average number of hours of sleep each night: _____ Do you wake feeling refreshed? ☐ Yes ☐ No

How many glasses of water do you drink each day (**Not** including tea, coffee, fruit drinks): _____

What sports or recreation do you participate in? _____

Average time spent exercising each day: _____

Medical History:

Surgeries:

_____

_____

Broken Bones:

_____

_____

Falls, accidents off bikes, car crashes:

_____

_____

Diagnosed Conditions &Medications:

_____

_____

Medical Doctor:

Name:_____Practice Name:_____

In order to work together toward your best outcome, we can send a report to your doctor to advise of our findings and your progress. Do you authorise us to release any medical information required to your doctor?

☐ Yes ☐ No

Chiropractic/Spinal Health History

Previous Chiropractor: Where: When:

Main reason for attending: How regular:

Were you happy with your results?

Relevant Female Section Only

Is there any chance you may be pregnant?	☐ Yes	☐ No
Are you Breast Feeding	☐ Yes	☐ No
Are you planning to conceive in the next 90 days?	☐ Yes	☐ No
Have you had any difficult pregnancies/ or suffered miscarriage?	☐ Yes	☐ No

DECLARATION: I, _____(print name) have understood (and sought clarification where I have not understood) the information provided above and answered all questions contained on this form accurately. My signature below acknowledges my consent to any examination procedures & X-rays if deemed appropriate/necessary by the Chiropractor. If this is an ACC Claim, I understand that ACC do not cover the full cost of examination and treatment and that I am responsible for those costs and the full fee if ACC decide to decline my claim. I consent to receiving my results via email.

Signature:_____**Date:**_____/_____/_____

CHIROPRACTORS SECTION ONLY

I have performed a clinical exam of this patient and now request an X-Ray exam.

The patient meets the following criteria:

☐	Trauma	☐	Aged over 50	☐	Neurological deficit
☐	Unexplained weight loss	☐	Inflammation	☐	Drug use / abuse
☐	Scoliosis assessment	☐	Steroid use	☐	Surgery in region
☐	Examination limited by pain	☐	Failure to improve	☐	Post anomaly
☐	Cancer history	☐	Equivocal biomechanical findings	☐	_____

No X-rays Required

☐ Unable to x-ray

☐ X-ray not warranted

X-Ray Examination:

☐	Cervical (AP / APOM & Lateral Cervical Spine)	☐	Thoracic (AP & Lateral Thoracic Spine)
☐	Lumbar (AP & Lateral Lumbar Spine)	☐	Other_____

Chiropractor:

_____**Signature:**_____**Date:**_____/_____/_____

OFFICE USE ONLY

☐	Scanned HH	☐	Patient Details	☐	Posture Photos
☐	X rays	☐	ACC	☐	Perfect Patients