

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: _____

Do you have a current ACC claim? No Yes Date of ACC injury: ____/____/____

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 tick any other health concerns you have below and rate them out of 10 (10 is worst imaginable) in severity

Neck Pain	0 1 2 3 4 5 6 7 8 9 10	Fatigue/low energy levels	0 1 2 3 4 5 6 7 8 9 10
Mid back pain	0 1 2 3 4 5 6 7 8 9 10	Poor concentration	0 1 2 3 4 5 6 7 8 9 10
Lower back pain	0 1 2 3 4 5 6 7 8 9 10	Nervousness/Depression	0 1 2 3 4 5 6 7 8 9 10
Shoulder pain	0 1 2 3 4 5 6 7 8 9 10	Allergies/sinus	0 1 2 3 4 5 6 7 8 9 10
Hip Pain	0 1 2 3 4 5 6 7 8 9 10	Asthma/bronchitis	0 1 2 3 4 5 6 7 8 9 10
Numbness and tingling in legs	0 1 2 3 4 5 6 7 8 9 10	Indigestion/heart burn	0 1 2 3 4 5 6 7 8 9 10
Numbness and tingling in arms	0 1 2 3 4 5 6 7 8 9 10	Bowel or bladder problems	0 1 2 3 4 5 6 7 8 9 10
Poor Posture	0 1 2 3 4 5 6 7 8 9 10	Constipation/diarrhea	0 1 2 3 4 5 6 7 8 9 10
Migraines	0 1 2 3 4 5 6 7 8 9 10	Menstrual problems	0 1 2 3 4 5 6 7 8 9 10
Headaches	0 1 2 3 4 5 6 7 8 9 10	Night sweats	0 1 2 3 4 5 6 7 8 9 10
Difficulty sleeping	0 1 2 3 4 5 6 7 8 9 10	Unexplained weight loss	0 1 2 3 4 5 6 7 8 9 10
Irritable/moody	0 1 2 3 4 5 6 7 8 9 10	Infertility	0 1 2 3 4 5 6 7 8 9 10
Dizziness/ringing in the ears	0 1 2 3 4 5 6 7 8 9 10	High/Low blood pressure	0 1 2 3 4 5 6 7 8 9 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Aged over 50 | <input type="checkbox"/> Neurological deficit |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Drug use / abuse |
| <input type="checkbox"/> Scoliosis assessment | <input type="checkbox"/> Steroid use | <input type="checkbox"/> Surgery in region |
| <input type="checkbox"/> Examination limited by pain | <input type="checkbox"/> Failure to improve | <input type="checkbox"/> Post anomaly |
| <input type="checkbox"/> Cancer history | <input type="checkbox"/> Equivocal biomechanical findings | <input type="checkbox"/> _____ |

No X-rays Required

- Unable to x-ray
- X-ray not warranted

X-Ray Examination:

- | | |
|--|---|
| <input type="checkbox"/> Cervical (AP / APOM & Lateral Cervical Spine) | <input type="checkbox"/> Thoracic (AP & Lateral Thoracic Spine) |
| <input type="checkbox"/> Lumbar (AP & Lateral Lumbar Spine) | <input type="checkbox"/> Other _____ |

Chiropractor:

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

OFFICE USE ONLY

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Scanned HH | <input type="checkbox"/> Patient Details | <input type="checkbox"/> Posture Photos |
| <input type="checkbox"/> X rays | <input type="checkbox"/> ACC | <input type="checkbox"/> Perfect Patients |