Welcome to iChiropractic

To help us to know more about you and your health status and needs please complete the following form

(Please talk to reception if you have any queries)

iChiropractic

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Personal Information

Todays Date: _____

Full Name: _____ Preferred Name: _____ Date of Birth: _____

Address: _____ Suburb: _____ Town: _____

Marital Status: *(circle 1)* - *Single / Married / De-Facto / Divorced* Spouses Name: _____

Phone Number: Home: _____ Work: _____ Mob: _____

Email Address: _____ ☐ (Please tick if you do not wish to be contacted by email)

Emergency Contact: _____ Relationship to you: _____ Contact no: _____

Your Occupation: _____ Your G.P.: _____ Contact no: _____

Previous Chiropractic Care: ☐ *Yes* ☐ *No* If *'yes'* then with whom: _____ Approx last visit: _____

How did you find out about us?: _____ Do you have any children? Ages?: _____
(If it is an existing patient please tell us their name so we may thank them)

The healthy function of every cell, tissue & organ in our bodies is dependent upon the integrity of the nervous system. This system consists of the brain, spinal cord and spinal nerves. Protecting these vital structures are the skull and the vertebrae of the spine. Chemical, Physical and Emotional stresses can upset the normal movement of the spinal bones interfering with the flow of information along the spinal nerves and throughout the nervous system. When this occurs it called a vertebral subluxation.

This questionnaire will help reveal the causes of vertebral subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and well-being.

Health History

What has brought you to our office today? _____

_____

What do you think has caused this problem? _____

When did this problem begin? _____

Was it: ☐ Sudden onset ☐ Gradual onset ☐ Result of an accident - if accident have you filled out an ACC form? Yes / No

Have you had this complaint before in the past? ☐ Yes ☐ No If 'yes' then when? _____

Have you sought care for this this problem previously? ☐ Yes ☐ No If 'yes' then when and with whom? (e.g. Physio, G.P, Osteo etc)

_____

What was the outcome of the care received? _____

Does anything make the problem worse? ☐ Yes ☐ No If 'yes', what? _____

Does anything make the problem better? ☐ Yes ☐ No If 'yes', what? _____

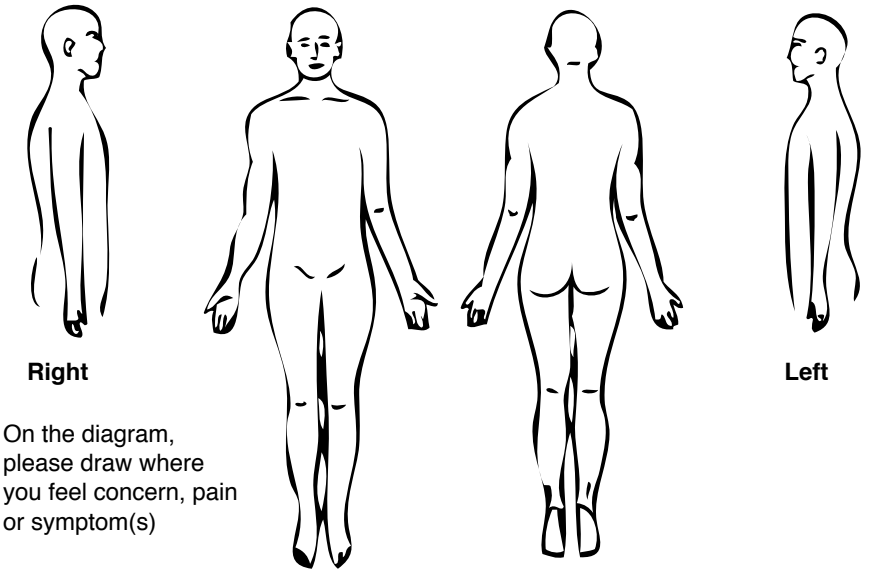
Is the problem getting better, getting worse or unchanged since it began? _____

Are there any daily activities that you have difficulty with or can no longer do? _____

Please circle the severity of your problem using the following scale if applicable:

1 2 3 4 5 6 7 8 9 10

No pain Extreme pain



Right **Left**

On the diagram, please draw where you feel concern, pain or symptom(s)

Please circle the following descriptor(s) that describe what you feel in relation to your current problem(s):

Sharp	Numbness	Cool/Cold
Dull	Tingling	Stiffness
Achy	Stabbing	Tightness
Burning	Shooting	Tension
Other		

Past History

Have you ever taken any trauma to your body? (e.g. Sporting injuries, falls, motor vehicle accidents etc) ☐ Yes ☐ No
If 'yes' please give details and dates: _____

Have you ever broken any bones? ☐ Yes ☐ No if 'yes' please state what and when: _____

Have you had any previous surgeries? ☐ Yes ☐ No
if 'yes' please give the details and approximate date:

Surgery: _____ Date: _____

Are you on any medications currently? ☐ Yes ☐ No
if 'yes' please give the details:

Medication: _____ Reason for taking: _____

Have you ever been treated for any major illness/conditions in the past? ☐ Yes ☐ No if 'yes' please give details below: _____

Please list any conditions or health problems that run in your family: _____

Please tick as appropriate of you have experienced any of the following in the **past** or at the **present:**

GENERAL
- ☐ Headaches / migraines
- ☐ Loss of energy
- ☐ Depression
- ☐ Nervousness / anxiety
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Allergy / hay fever
- ☐ Weight gain / loss
- ☐ Loss of consciousness / concussion
- ☐ Epilepsy / convulsions
- ☐ Dizziness / fainting spells
- ☐ Nausea / vomiting
- ☐ Fever / chills
- ☐ Night sweats
- ☐ Loss of sleep

EYES, EARS, NOSE & THROAT
- ☐ Recurring earache(s)
- ☐ Ringing in the ears / tinnitus
- ☐ Deafness
- ☐ Visual disturbances / changes
- ☐ Eye pain
- ☐ Recurring sinus infection
- ☐ Recurring sore throat / tonsillitis
- ☐ Recurring colds
- ☐ Enlarged thyroid / goitre
- ☐ Enlarged glands
- ☐ Ulcers
- ☐ Hoarsness

WOMENS HEALTH
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Menopausal symptoms
- ☐ Breast Lumps
- ☐ Ovarian cysts
- ☐ Miscarriage
- ☐ Pregnant

CARDIO-VASCULAR
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Angina
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

GASTRO-INTESTINAL
- ☐ Always hungry / thirsty
- ☐ Loss of appetite
- ☐ Irritable bowel disease
- ☐ Food allergies
- ☐ Stomach ulcer
- ☐ Stomach pain
- ☐ Hernia
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Difficult digestion
- ☐ Inability to control bowel
- ☐ Liver trouble / jaundice
- ☐ Gallbladder trouble
- ☐ Hepatitis
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Haemorrhoids
- ☐ Reflux / indigestion

RESPIRATORY
- ☐ Difficulty breathing / emphysema
- ☐ Asthma
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Chest pain
- ☐ Spitting / coughing up blood
- ☐ Tuberculosis (TB)
- ☐ Rheumatic fever

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Neck pain or stiffness
- ☐ Pain between the shoulders
- ☐ Shoulder / arm pain
- ☐ Low back pain / lumbago
- ☐ Sciatic / leg pain
- ☐ Hip / knee pain
- ☐ Ankle / foot pain
- ☐ Disc injury
- ☐ Muscle weakness / wasting
- ☐ Gout
- ☐ Fractures
- ☐ Jaw pain / TMJ problems
- ☐ Pins & needles
- ☐ Numbness
- ☐ R.S.I. / O.O.S.
- ☐ Osteoporosis
- ☐ Poor posture
- ☐ Spinal curvatures

GENITO-URINARY
- ☐ Frequent urination
- ☐ Inability to control bladder
- ☐ Painful urination
- ☐ Recurring bladder infection
- ☐ Kidney trouble
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Blood in urine
- ☐ STD's
- ☐ Bedwetting

Are there any other past or present health problem not mentioned above? ☐ Yes ☐ No if 'yes' please explain below:

_____

_____

_____

Lifestyle - *Physical, chemical and mental stresses*

In general, would you say your health is: (please circle)	1 Excellent	2 Very Good	3 Good	4 Fair	5 Poor
In general, how would you rate your energy levels: (please circle)	1 Excellent	2 Very Good	3 Good	4 Fair	5 Poor

Physical stress on the body is the most obvious cause of vertebral subluxations. Jolts falls or trauma through accidents or lifestyle activities like sports that occur at any age can also be responsible for present day subluxations if the body was not able to adapt to that force. Many experts agree that the birth process is often very traumatic.

Do you exercise e.g. gym, sports, walking? ☐ Yes ☐ No if 'yes', what? _____

_____

How often do you exercise for more than 30 minutes per day? (please circle)

Every day 5-6 days/week 3-4 days/week 1-2 days/week 0 days/weeks

What level of activity is the exercise? (please circle) Vigorous activity Moderate activity Light activity

Prolonged abnormal postures or subtle repetitive movements often place stress on our spine and nervous system.

How would you describe your posture? (e.g. hunched, normal, weak, lob-sided) _____

Does your typical day involve any of the following? (please tick)

☐ Heavy lifting
☐ Frequent bending
☐ Shift work
☐ Repetitive movements
☐ Vigorous activity
☐ Prolonged time sitting

If prolonged sitting, is it in front of a computer? ☐ Yes ☐ No

What position do you sleep? On your: ☐ Front ☐ Side ☐ Back ☐ All over

Possible chemical causes of subluxations include poor nutrition, drugs/medication and environmental toxins.

In general how would you rate your diet? (please circle)

1 Very healthy 2 Healthy 3 Moderately healthy 4 Unhealthy 5 Very unhealthy

How many glasses of water do you drink per day? _____ Is this water filtered? ☐ Yes ☐ No

Do you drink coffee or tea? ☐ Yes ☐ No if 'yes', how many cups per day? _____

Do you smoke? ☐ Yes ☐ No if 'yes', how many cigarettes per day? _____

Most of us notice that when we are stressed we are more likely to get sick. Our emotional status has a major impact on our nervous and immune systems, and many studies have supported this link.

Do you frequently suffer from any of the following: (please tick any that apply)

☐ Fatigue / Tiredness
☐ Anxiety / Nervousness
☐ Insomnia / Poor sleep
☐ Anger
☐ Grumpiness
☐ Depression
☐ Negative thoughts / Attitude
☐ Low motivation
☐ Irritability
☐ Poor concentration
☐ Hyperactivity
☐ Easily losing patience

Have you ever experienced an emotionally traumatic event or a period of severe stress or grief? ☐ Yes ☐ No
if 'yes', when and why? _____

How would you rate your current level of stress? (circle) 1 Very high 2 High 3 Moderate 4 Low 5 Very low

Is there any further information you would like us to know? _____

Consent for care

As with all health care professionals the law now requires practitioners who adjust the spine to inform patients of material risk. Chiropractic adjustments of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and many other alternatives. (A risk assessment cervical of manipulation, JMPT, 1995.Magna Report, Ontario Ministry of Health, 1993). In extremely rare circumstances some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke like symptoms. This is extremely rare occurring in approx 1 in 5.85 million (Haldeman, et al. Spine, 1999, Vol 24-8). Whilst this has never occurred in this practice, we are still required to impart this information. Before you receive any adjustments you will be tested to minimise risk, as has always been our practice. If you have any questions related to the care you are about to receive please speak to the chiropractor.

Please sign below if you give permission for the chiropractor to examine and administer care as deemed necessary. For patients under the age of 18, a parental guardian must sign below.

Signature: _____ Date: _____