

Personal Details

CONFIDENTIAL

TITLE: (Please circle) Dr / Mr / Mrs / Ms FIRST NAME(s): _____

_____ SURNAME: _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE HOME: _____ PHONE WORK: _____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDATE: _____ 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 []

No [] We will make sure we explain everything as we go.

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

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 _____

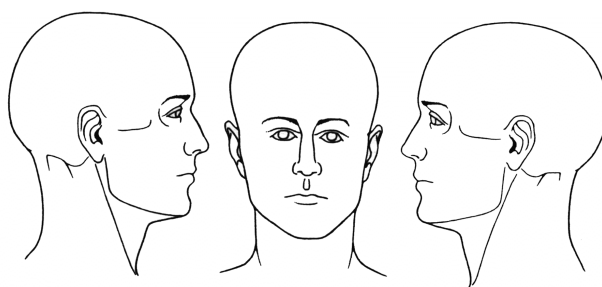
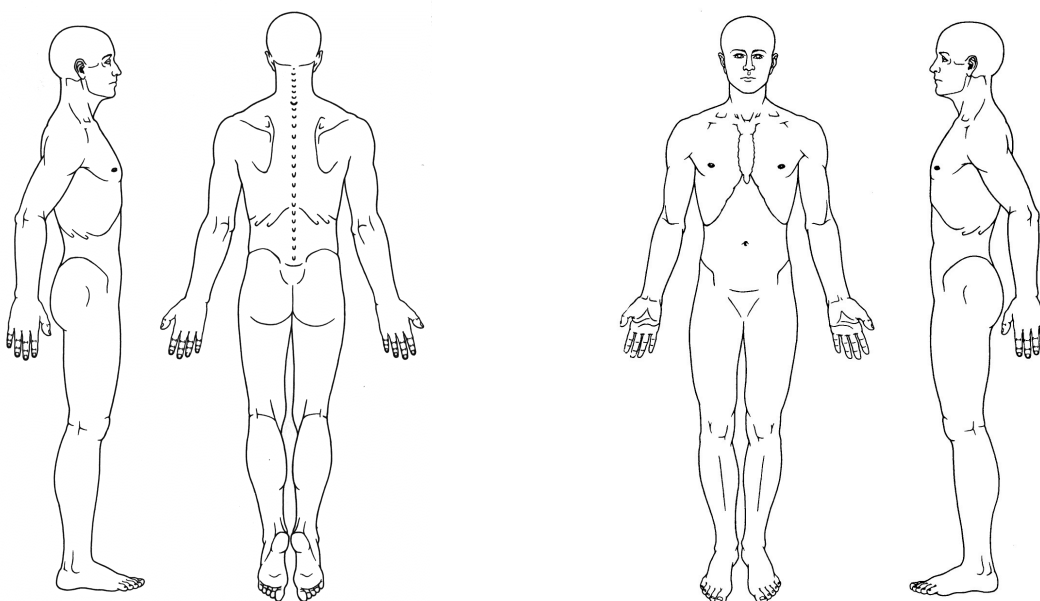
Weakness in either arm or leg Yes / No _____

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

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

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

The Ashgrove Spinal Centre

- 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 _____

The Ashgrove Spinal Centre

- 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 _____
- Do you get cold hands or feet? Yes / No _____
- Do you have varicose veins? Yes / No _____

The Ashgrove Spinal Centre

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 _____

This practice specialises in treating 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)