Northern Beaches CHIROPRACTIC

CONFIDENTIAL PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Title: ..... First Name: ..... Surname: .....
Address: .....
Suburb: ..... Postcode: .....
Telephone: Home: ..... Mobile: ..... Work: .....
Email Address: .....
DOB: ..... Age: ..... Occupation: .....
Marital Status: ..... Partner's name: ..... No. of Children .....
Emergency contact name: ..... Relationship to you: .....
Emergency Contact Phone: .....
General Medical Practitioner: ..... Phone: .....

Is this a Workcover/TAC/DVA claim? Yes/No Claim number: .....
Do you have private health insurance? Yes/No Name of fund: .....

Is this your first visit to a chiropractor? Yes/No
If you have had previous chiropractic care, please complete the following
Name of chiropractor: ..... Location: .....
When was your last treatment? ..... How many treatments were given? .....
Were the results of the treatment Excellent/Satisfactory/Unsatisfactory?
Did the chiropractor use x-rays? Yes/No

How did you hear about Northern Beaches Chiropractic?

- ☐ Yellow Pages
- ☐ Google
- ☐ Signs
- ☐ Local Directories
- ☐ Facebook
- ☐ Flyers
- ☐ GP/other practitioner referral: .....
- ☐ Friend/Family: .....
- ☐ Other: .....

Northern Beaches CHIROPRACTIC

PATIENT HISTORY QUESTIONAIRRE

The following questions are to help your chiropractor diagnose your condition and develop the best treatment plan for you.

GENERAL HEALTH STATUS

Do you suffer, or have you suffered any of the following:

- ☐ Asthma
- ☐ Allergies
- ☐ Arthritis
- ☐ Blood Pressure High/Low
- ☐ Cancer
- ☐ Chest pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Gastrointestinal complaints
- ☐ Headache
- ☐ Heart issues
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Malaria
- ☐ Menopause
- ☐ Migraine
- ☐ Pain/numbness/tingling
  - ○ Arm/Hand
  - ○ Leg/Foot
  - ○ Neck
  - ○ Mid Back
  - ○ Low Back
- ☐ Polio
- ☐ Recent weight gain/loss
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Stiffness
- ☐ Stress
- ☐ Stroke
- ☐ Swelling of joints/limbs
- ☐ Thyroid problems
- ☐ Vertigo
- ☐ Visual disturbance

- ☐ Smoke _____ day
- ☐ Alcohol _____ day

- ☐ Other _____

Please list:

- any hospitalizations you have had in the past _____

- drugs, medications or vitamins/minerals that you take _____

- any exercise/sports/activities _____

Females only: are you pregnant? Yes/No Are you taking the contraceptive pill? Yes/No

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Northern Beaches CHIROPRACTIC

PATIENT HISTORY QUESTIONNAIRE

What is your main complaint?

.....

.....

.....

.....

How did it start?

.....

.....

.....

How long have you had it? .....

Have you had it in the past? Yes/No

How often are you experiencing it?

.....

.....

.....

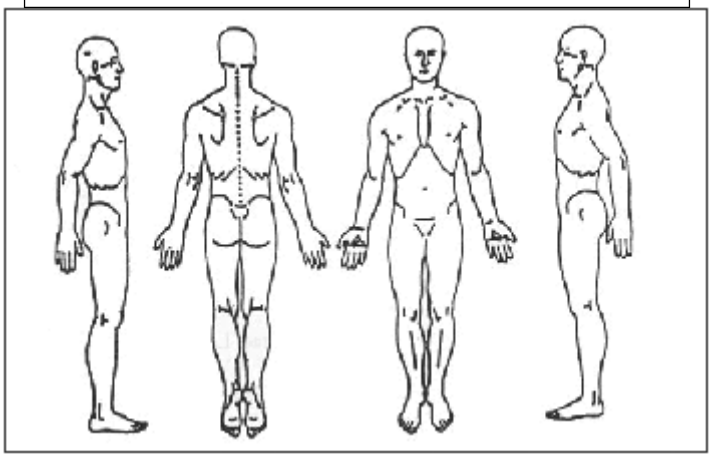
What activities aggravate the complaint?

.....

.....

.....

Please mark the area/s of complaint on the diagram below



Pain scale- please mark

No Pain 0 ——— 10 Worst Pain

What activities relieve the complaint? .....

.....

Have you had any other treatment for this complaint?: .....

Is it: ☐ Getting better ☐ Getting worse ☐ Staying the same

Is it: ☐ Constant ☐ On & Off

Would you describe the pain as: ☐ Dull ☐ Achey ☐ Sharp ☐ Stabbing
☐ Shooting ☐ Burning ☐ Tingling ☐ Numb ☐ .....

Is it interfering with your: ☐ Work ☐ Sleep ☐ Sport ☐ Daily activities

Do you have any other complaints? .....

.....

.....

Have you ever had any falls, broken bones or other injuries, childhood accidents, motor vehicle accidents? .....

.....

.....

Do you have a family history of: ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Nervous system disorder ☐ Muscular disorder ☐ .....

Signature ..... Date .....

Northern Beaches
CHIROPRACTIC

CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about. Please read the following carefully:-

1. I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

……
……

3. I have had the opportunity to discuss the proposed care with my chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by my chiropractor and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.
7. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."

……
Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

……
Patient's Name (printed)

……
Chiropractor's Signature

Dated:……

CHIROPRACTOR'S USE ONLY

Northern Beaches CHIROPRACTIC

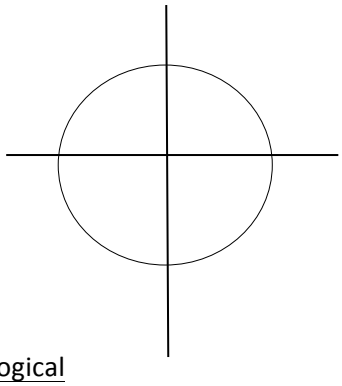
PHYSICAL EXAMINATION

Vital signs: BP: ..... Pulse: ..... Resp: ..... Temp: .....

Height: ..... Weight: .....

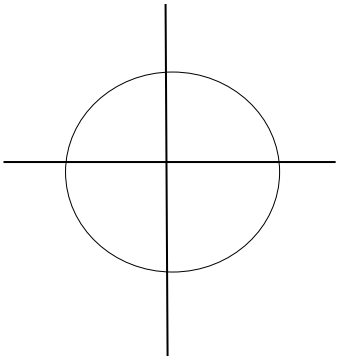
ROM:

Cervical



Normal Ranges		
60	Flexion	90
30	Extension	30
45	Lat Flexion	20
90	Rotation	30

Lumbar



Neurological

Myotomes:

Dermatomes:

Nerve	Action	L	R	Nerve	Action	L	R
C5	Sh Abd			L2,3,4	Hip Flex		
C5,6	Elb Flex			L3,4	Knee Ext		
C6	Elb Ext			L2,3,4	Knee Flex		
C7	Wrist Ext			L4,5	Dorsiflex		
C7,8	Wrist Flex			S1,2	Plantar Flex		
C8	Fgr Flex			L5	Hallux Ext		
T1	Fgr Abd			L4,5,S1	Hip Ext		

DTR's	L	R		L	R
C5			L4		
C6			S1		
C7					

Cervicothoracic	L	R	Notes
Maigne's			
Compression			
Max Comp			
Distraction			
Sh depression			
Adson's			
Adam's			

Extremity			

Working diagnosis/Notes

Lumbar	L	R	Notes				Notes
Kemp's @				FABERE			
Slump				Yeomann's			
DLR				Iliac Comp A-P			
SLR				Iliac Comp lat			
Braggard's				Mennell's			