

Mount Hawthorn Chiropractic Clinic

Chiropractic Health Questionnaire

The information on this form is, and will remain, strictly confidential.

Sinus Troubles:

- recurrent ear infections / problems
- recurrent throat infections / problems
- recurrent sinus infections / problems
- hay fever

Respiratory Troubles:

- asthma
- recurrent cough
- recurrent chest infections / problems
- history of pneumonia / bronchitis

Digestive Troubles:

- indigestion / heartburn
- gastric / duodenal ulcers
- bloating
- chronic nausea / vomiting
- abdominal pain / cramping

Cardiac Problems:

- hypertension (high)
- hypotension (low)
- heart murmur / arrhythmia

Bowel / Bladder Troubles:

- constipation / diarrhoea / haemorrhoids
- urinary tract infection
- frequent urinations
- pain on bowel movements / urination

Menstrual Troubles:

- pain / irregularity / spotting / excessive bleeding
- endometriosis / cysts / fibroids
- recurrent infection

Date: _____

Name: _____
Surname Given names Mr/Mrs/Ms/Miss/Mstr/Dr

Address: _____
Number and street Suburb/Town Postcode

Home Phone: _____ Email: _____

Mobile: _____ Private Health Fund: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: Name/Phone: _____

PREGNANCY:

Is there a possibility that you might be pregnant? Y / N (please circle)

X-RAYS:

Have you ever had any spinal x-rays taken? Y / N (please circle) If yes, when? _____

Were they taken with you lying down or standing? _____

MEDICATIONS:

What medications are you currently taking? _____

What vitamin/supplements are you currently taking? _____

ACCIDENTS/FRACTURES/OPERATIONS:

Have you had any hospitalisations or operations? Y / N (please circle)

Please explain: _____

Accidents and/or injuries:

If yes, when? _____

LIFESTYLE:

What sports, activities, hobbies do you engage in? _____

Do you smoke? Y / N (please circle)

Do you drink alcohol? Y / N (please circle) If yes, how often? _____

Do you get adequate levels of rest? Y / N (please circle)
(A minimum of 8 hours per night is recommended)

Do you drink adequate levels of water? Y / N (please circle)
(A minimum of 2 litres per day is recommended)

Do you get adequate levels of exercise? Y / N (please circle)
(A minimum of 30 minutes a day is recommended)

Do you consider your diet to be healthy and balanced? Y / N (please circle)

Do you have any other health concerns? _____

HISTORY

EXAMINATION FINDINGS

X-RAYS LISTINGS

In our day-to-day living, one is exposed to many seemingly small stressors in the form of physical, chemical and mental factors. Albeit these are commonly small, they tend to have an accumulating effect on the body and subsequently one's quality of life. Please rate your level of exposure to the following stressors:



Physical (e.g. postures, fall etc...) ___ / 10

Chemical (e.g. toxins, poor diet, drugs etc...) ___ / 10

Mental (e.g. emotional stress - work, relationship, study etc...) ___ / 10

People who consult MHCC commonly have different health objectives. Which of the following are relevant to you? (Choose all that apply or relevant to you).

- Relief of presenting symptoms
- Correction of underlying problems leading to presenting symptoms
- Optimisation of personal health and wellbeing

People consult with chiropractors for a wide variety of reasons. Why have you chosen to consult with the chiropractors at MHCC?

Chiropractic is radically simple! Chiropractic focuses on the relationship between the spine and nerve system, which includes the brain. Correct, full and appropriate movement of the spine is what drives the function of the nerve system. It is the nerve system which controls every function, from an individual cell up to muscles, organs and skin, of the human body.

A HEALTHY SPINE = A HEALTHY NERVOUS SYSTEM = A HEALTHY BODY

WHO MAY WE THANK FOR REFERRING YOU?

(How did you hear about us?)

Informed Consent to Chiropractic Care

It is our intention to help you in the restoration of your health. We are obliged to inform you of any potential risks in the delivery of your chiropractic care. The Doctors of Mt Hawthorn Chiropractic Clinic exclusively use the Gonstead system of Chiropractic in the delivery of your care. Chiropractic is safe and effective. However, for certain groups of people (those with predilection to strokes, blood and arterial disorders), some form of risk can be involved. The latest study regarding the risk of stroke caused by manual adjustment is 1 in 5.85 million (neck manipulations. Haldeman, et al. Spine vol. 24-8 1999). Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives (A Risk Assessment of Cervical Manipulation, JMPT 1995). Other slight risks include strain injury to a ligament or disc in the neck or low back (less than 1 in 139,000). (Dvorak study in Principles and Practice of Chiropractic, Heldeman. 2nd ed).

In context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs and even driving a car. Some people may experience some mild soreness for 24-48hrs after their adjustments. This may be due to the body making the necessary changes of "unwinding or retracting". This is normal, as may be experienced after exercise and/or stretching. Clinical experience consistently demonstrates unexpected improvement in ones/a person's life. One study has indicated that 23% of people experience improvements in other aspects of their health.

Of individuals who experience such improvements -

- 26% experienced improvements in their respiratory system
- 25% in their digestive system
- 14% in their circulatory system/cardiovascular function
- 14% with their eyes/vision

More specifically -

- easier to breathe 21%
- improved digestive function 20%
- clearer vision 11%
- better circulation 7%
- changes in blood pressure and heart rhythm 5%
- improved hearing and reduced ringing in the ears 4%

I have read and understood the above information. I do not expect the chiropractor to be able to anticipate all risks and/or complications. I wish to rely on the chiropractor to exercise their clinical judgement based on skill, knowledge and experience to make decisions for my best interests.

I have, to the best of my knowledge, provided the chiropractor with a complete and accurate health history.

I have had the opportunity to discuss with the chiropractor the nature and purpose of my chiropractic care. I understand that results are not guaranteed.

I intend this consent to cover the entire course of recommended chiropractic care for this and for any further presentation.

I hereby request and consent to chiropractic care wherever the chiropractor deems necessary. By signing this form I agree to chiropractic care.

Dated this ____ day of _____, 20____.

Patient's Signature

Chiropractor's Signature

Parent/Legal Guardian's Signature

(please print)

Minor's name (please print)

please turn over