Welcome to the Toowoomba Clinic for Spine Related Disorders

Personal Details

CONFIDENTIAL

*PLEASE USE **BLACK PEN***

NAME: Dr /Mr /Mrs /Ms

_____

ADDRESS:

_____

_____POSTCODE: _____

PHONE _____PHONE WORK: _____

MOBILE PHONE: _____EMAIL: _____

BIRTHDATE: _____OCCUPATION: _____

PARTNER'S NAME: _____NO. OF CHILDREN: ___

Do you belong to Health fund? If yes, to which one?

_____

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)? _____

Do you give your chiropractor permission to communicate with your G.P. yes/no

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 [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Would you like to receive a monthly Health and Wellbeing Newsletter by email?
Yes [ ] No [ ]

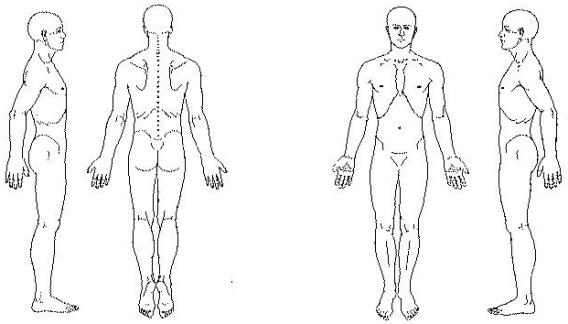
If yes, please mark the health subjects that most interest you:

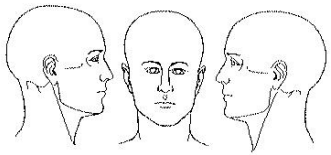
[ ]	Headaches and Neck Pain	[ ]	Wellness Topics
[ ]	Backaches and Sciatica	[ ]	Diet and Nutrition
[ ]	Children's Health Issues	[ ]	Exercise and Fitness
[ ]	Women's Health Issues	[ ]	Stress Management

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating your spine and neurological function.

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.





Major Complaint

What is your main problem? _____

_____

When and how did it start? _____

How does this problem rate out of 10 (10 bad, 0 nothing) _____

Was there any of the following prior to or during the onset? (Please circle)

- Illness / infection _____
- Trauma _____
- Other significant event/ emotional stress _____

Is your problem getting worse? Yes / No _____

What relieves your symptoms? _____

What aggravates your symptoms? _____

Are your symptoms worse at night or any specific time of the day? _____

_____

Does your current problem involve any of the following? If Yes, where?

Pain 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 _____

Poor balance Yes/ No_____

Restricted movement Yes/ No_____

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

_____

Is this complaint interfering with any activities? eg sleep, work, sport, hobbies, other?

_____

What are your goals with care? eg. Full recovery with full function and no pain, less pain? _____

Medical History & General Health

What medications are you currently taking?

_____

Have you had any surgery (over lifetime?)

_____

Please list any physical trauma over your lifetime? (falls, car accidents, sport injuries, work injuries, broken bones, sprains)_____

Please list any chronic diseases you may have (cancer, diabetes, heart disease, obesity)

_____