CONFIDENTIAL PATIENT INFORMATION

Date:..

Please complete this questionnaire. Your answers will help us to determine whether chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept, your case.
This report is confidential and is treated as such by our staff.

Mobile ____________

Name ____________ Home Phone ____________

Address ____________ Post Code ____________

Birth Date ____________ Age ______ Marital: S M W D SEP. HOW MANY CHILDREN ______

OCCUPATION ____________ EMPLOYER ____________

ADDRESS ____________ Office Phone ____________

Name of Wife or Husband ____________ Family Doctor ____________

Referred to this clinic by: ____________

THIS SECTION TO BE COMPLETED BY WORKCARE/TAC PATIENTS ONLY: ALL patients to complete reverse side of this form:

Date of Accident ______ Hour ______ AM/PM ______ Location ____________

How did Accident occur? (Circle) On-the-job Injury Car Accident Other ______

If an "On-the-job" injury, please describe the circumstances: ____________

____

____

Did you report the injury to your Foreman or Employer? Yes / No Did He (They) recommend care at our office? Yes / No

If Car Accident, were you the Driver Passenger Pedestrian Cyclist Wearing Seat Belt

If Car Accident, were you struck from Behind Right Side Left Side Front Car Was Stationary

Did your Car strike the other(s) involved? Yes / No Or did the other car strike yours? Yes / No / Unsure

List the extent of your injuries as you know them: ____________

____

____

____

Did you require post-accident hospitalization? Yes / No Which Hospital ____________

Were X-Ray or other tests performed? Describe ____________

SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT: (Please Tick)

[ ] Headache	[ ] Irritability	[ ] Numbness in Toes	[ ] Face Flushed	[ ] Feet Cold
[ ] Neck Pain	[ ] Chest Pain	[ ] Shortness of Breath	[ ] Buzzing in Ears	[ ] Hands Cold
[ ] Neck Stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of Balance	[ ] Stomach Upset
[ ] Sleeping Problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting	[ ] Constipation
[ ] Back Pain	[ ] Pins & Needles in Arms	[ ] Lights Bother Eyes	[ ] Loss of Smell	[ ] Cold Sweats
[ ] Nervousness	[ ] Pins & Needles in Legs	[ ] Loss of Memory	[ ] Loss of Taste	[ ] Fever
[ ] Tension	[ ] Numbness in Fingers	[ ] Ears Ring	[ ] Diarrhoea	[ ] ______

Symptoms other than above: ____________

Treatment received to date: ____________

____

____

Have you lost any days off work? Yes / No How many? ______ Dates: ____________

Insurance Company Involved:

My Company ____________

Company of Person Responsible for Injuries ____________

Have you been contacted by the Insurance Company Regarding this Claim Yes / No.

Do you have a Solicitor who has advised you in this case? Yes / No Name ____________

Address ____________ Phone ____________

Workcare or Transport Accident Commission Claim No: ____________

FOR WOMEN ONLY

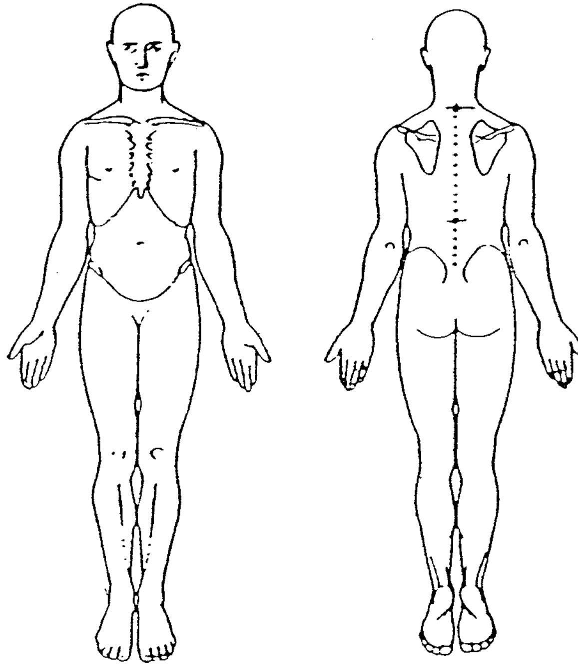
1. Painful menstruation ...
2. Cramps ...
3. Irregular cycle ...
4. Excessive flow ...
5. Lumps in breast ...
6. Vaginal discharge ...
7. Menopausal symptoms ...
8. Hot flushes ...
9. Previous miscarriages
10. Are you pregnant? YES/NO

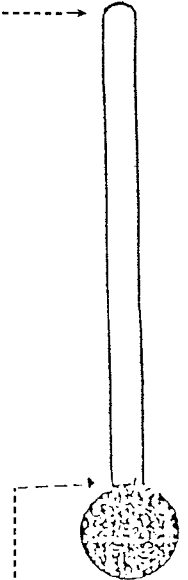
THIS SECTION TO BE COMPLETED BY ALL PATIENTS:

Have you ever suffered from (please tick):

1. Dizziness ...
2. Headaches ...
3. Neck Pain ...
4. Shoulder/Arm pain ...
5. Chest/Rib pain ...
6. Lung disorders ...
7. Asthma ...
8. Heart Disease ...
9. Blood pressure ...
10. Digestive problems ...
11. Constipation/Diarrhoea ...
12. Lower back pains ...
13. Leg Pains ...
14. Arthritis ...
15. Skin problems
16. Numbness//tingling...
17. Cramps ...
18. Nervousness ...
19. Cancer ...
20. Aids or STD ...
21. Circulatory problems ...
22. Kidney/Bladder problems ...
23. ______________________
24. ______________________

SITES OF PAIN





Please mark on the charts above where your worst pains are, and on the pain barometer, the level at which you feel your worst pain.

Have you ever required psychiatric care? YES / NO WHEN?______________________

Have you any hereditary complaints? Describe______________________

What Operations Have You Had? When?______________________

____

____

Serious Illnesses & When? ______________________

Any Fractures & When? ______________________

Purpose of this appointment:______________________

Other Doctors Seen For This Condition______________________

Have you been treated for any health condition by a doctor in the last year? YES / NO Describe______________________

____

What medications or drugs are you taking?______________________

It is the policy of this clinic that all services are payable at the time of visit otherwise a book-keeping fee is added. All Workcare and Transport Accident Claims are processed in the usual way, however should a claim be disputed for some reason, then payment for outstanding fees becomes the responsibility of the patient.

Once we have completed your case history, examination, and performed whatever tests are necessary to diagnose your condition, we shall advise you as to whether we feel chiropractic care is indicated or not. Should we accept your case wherever possible we shall use either no-force or low force procedures to help you. As with any procedure though there is always an element of risk however small that may be. Please be assured that every possible precaution will be taken to render safe and effective care.

I have read and understood all the above questions and statement.

Signed ______________________
(If under age, Parent or Legal Guardian)