Nepean Centre for Spinal Health

Personal Details

CONFIDENTIAL

PLEASE USE BLACK OR BLUE PEN ONLY

NAME: Dr/Mr/Mrs/Ms_____

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

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_____

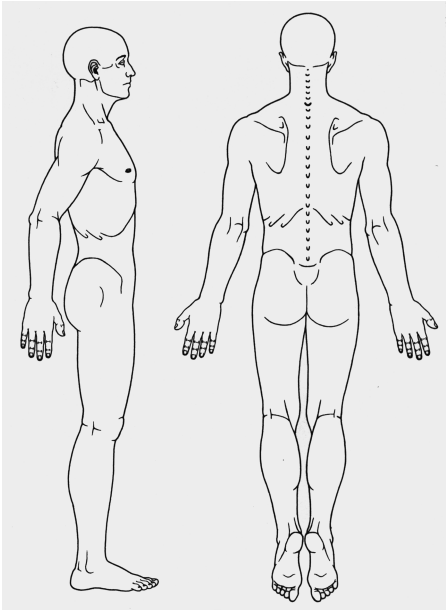
'Weird' sensations in either arm or legYes / No_____

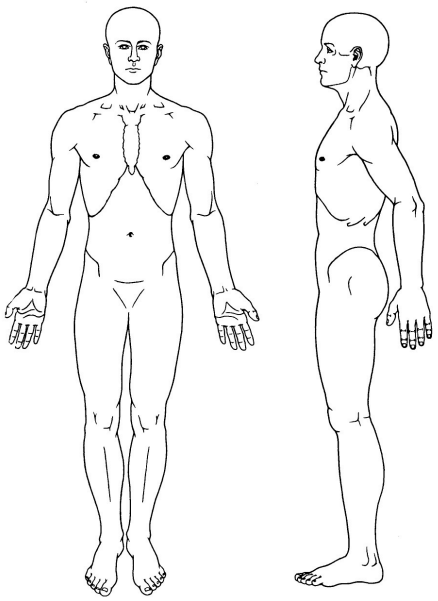
Have you had any other treatment for your current problem? Yes / No _____

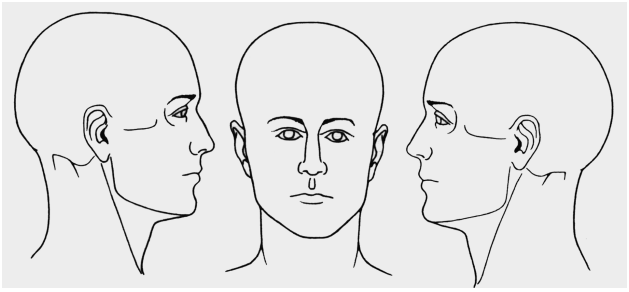
_____

Where is the Problem?

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







How does this pain affect your life? _____

_____

How does this pain affect your life? _____

_____

What will you be like in 12 months from now if this doesn't change? _____

_____

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

_____

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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_____

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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

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Do you get cold hands or feet? Yes / No_____

Do you have varicose veins? Yes / No_____

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)