

Confidential Patient Case History

DEAR PATIENT: Please complete this questionnaire.
Your answers will help us to determine if Chiropractic can help you.

Name..... Today's Date...../...../.....
 Address..... Suburb..... Post Code.....
 Phone: Home..... Work..... Mobile.....
 Email: D.O.B...../...../.....
 Marital Status..... Children? How many?
 Occupation..... How did you find out about us?
 Do you have Private Health Cover? Yes / No Which fund?

**Please tick if you have suffered from any of the following symptoms,
whether past or present:**

- | Past
Present | Past
Present | Past
Present |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Chronic/ frequent headaches | <input type="checkbox"/> <input type="checkbox"/> Pain in ribs | <input type="checkbox"/> <input type="checkbox"/> Chronic cough/Asthma |
| <input type="checkbox"/> <input type="checkbox"/> Pain in head | <input type="checkbox"/> <input type="checkbox"/> Low back pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Frequent nausea/vomiting |
| <input type="checkbox"/> <input type="checkbox"/> Soreness in neck | <input type="checkbox"/> <input type="checkbox"/> Low back weakness | <input type="checkbox"/> <input type="checkbox"/> Digestive malfunction |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Hip pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> <input type="checkbox"/> Buttock pain | <input type="checkbox"/> <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> <input type="checkbox"/> Arm pain | <input type="checkbox"/> <input type="checkbox"/> Leg pain/cramps | <input type="checkbox"/> <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> <input type="checkbox"/> Loss of arm power | <input type="checkbox"/> <input type="checkbox"/> Frequent pins & needles in legs or feet | <input type="checkbox"/> <input type="checkbox"/> Menstrual disorders |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Knee pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Loss of potency |
| <input type="checkbox"/> <input type="checkbox"/> Elbow pain | <input type="checkbox"/> <input type="checkbox"/> Ankle pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Other sexual disorders |
| <input type="checkbox"/> <input type="checkbox"/> Wrist or hand pain | <input type="checkbox"/> <input type="checkbox"/> Foot pain/stiffness | <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> <input type="checkbox"/> Pins & needles in hands | <input type="checkbox"/> <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> <input type="checkbox"/> Other..... |
| <input type="checkbox"/> <input type="checkbox"/> Loss of grip | <input type="checkbox"/> <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> <input type="checkbox"/> Mid back pain/tension | <input type="checkbox"/> <input type="checkbox"/> Sinus trouble | |

Present Symptoms

What are your present symptoms?

Original onset date? Recent onset date?

Caused by?

Previous treatment? Result?

Have you had any X-rays CT Scans MRIs recently? Location?

Any family history of this problem? Yes / No

Are you symptoms aggravated by, or related to, your work? Yes / No

What medications are you taking?

Have you seen a chiropractor before? Yes / No

Do you sleep on your **Side / Back / Stomach**? Do you have a **Soft / Medium / Hard** mattress?

How many pillows do you use?

(Female only) Is there any possibility that you might be pregnant? Yes / No

FINANCIAL POLICY: We would appreciate payment at time of consultation.

Patient Information

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risk. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke-like symptoms (approx.. 1 in 5.85 million neck manipulations. Haldeman, et al. Spine vol. 24-8 1999). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) (Dvorak study principles and Practice of Chiropractic, Haldeman, 2nd Ed.).

Chiropractic adjustments (manipulations) 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. Manga report, Ontario Ministry of Health, 1993).

If you have any questions related to the treatment you are about to receive, please speak to the Chiropractor.

I have discussed the above information with the Chiropractor and give my consent to treatment.

Patient's Signature **Print Name**

Chiropractor's Signature **Date**/...../.....

DO YOU AUTHORISE ANY PERSON TO MAKE OR CHANGE APPOINTMENTS ON YOUR BEHALF?

Nominated Person: **Relationship:**

Sign:

Noosa Life Chiropractic

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