POSTURE CHIROPRACTIC

Health Questionnaire (Strictly Confidential) Date / /

1. PATIENT INFORMATION			
Given name:	Surname:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	D.O.B: / /
Address:		Suburb: Post code:	
Contact number:	Emergency contact name /Number/ Relationship to you		
Occupation:	Email Address:		
Children / age:	Referred by:		

2. PROBLEM or CONDITION

Please state the reason for today's visit? ……
…….
…….

How is this impacting on your life? (E.g. exercise, work, sleep, general activities?)
…….
…….
…….
…….
When did you first notice this?.....
…….
…….
…….
…….
Has it happened before? ☐Yes ☐No If yes, when? ……..
…….
What treatment have you had so far? ……
……..
……..
Did it help? ……

On scale from 0 to 10, How do you rate your current pain?

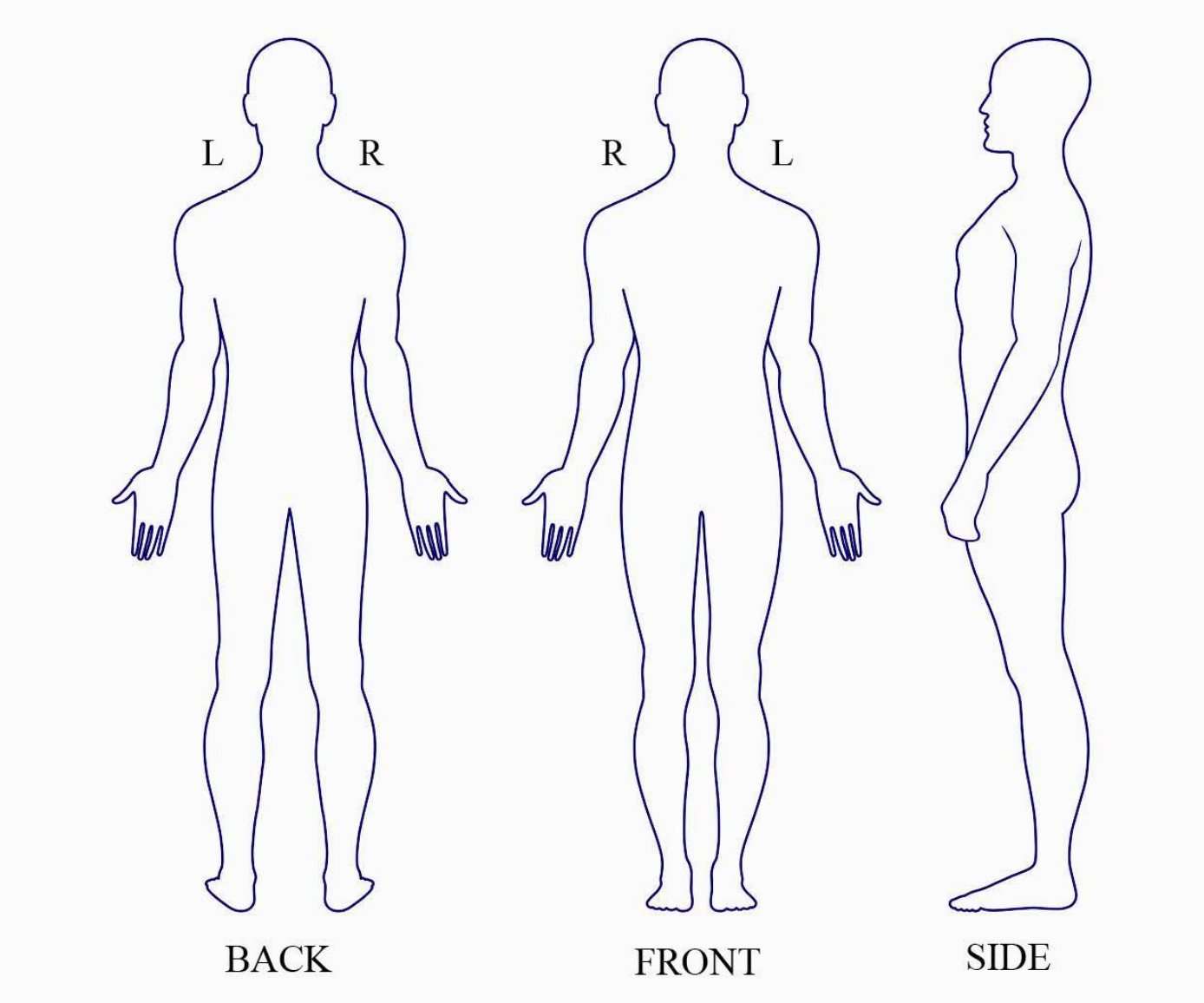
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please mark on the attached diagram (next page) *where* you have *pain* and/or other *symptoms*.

Indicate on the diagram where you have pain or symptoms.

Please use these symbols to indicate sensation:

(**X**) For pain (**O**) For numbness / pins and needles



Are your symptoms:

Increasing ☐ Decreasing ☐ Not changing ☐

Practioner's notes: ……..
……...
……
……..
……

3. MEDICAL HISTORY

Please indicate if **you** suffer or have suffered from any of the following:
☐Cancer ☐Stroke ☐Diabetes ☐High Cholesterol ☐High/low blood pressure ☐Osteoporosis
☐Fractures ☐Dislocation ☐Excessive bruising/bleeding ☐Swelling of lymph nodes
☐Unexplained weight loss ☐Night sweats ☐Bowel or bladder problems ☐Heart problems
☐Dizziness/fainting ☐Headaches/Migraines.

Please indicate if **your family** suffer or have suffered from any of the following:
☐Cancer ☐Stroke ☐Diabetes ☐High Cholesterol ☐High/low blood pressure ☐Osteoporosis
☐Fractures ☐Dislocation ☐Bowel or bladder problems ☐Heart problems
☐Dizziness/fainting ☐Headaches/Migraines.

Please list your current medications and supplements.

…….

……

Have you ever been hospitalized? ☐Yes ☐No
If yes, when and for what condition? ……

Please indicate the main issues you wish to address during your treatment:

☐Pain management/relief ☐Posture correction ☐Improve sleep quality ☐Increase energy levels
☐Enhance sporting performance ☐Prevent spinal decay ☐Increase immunity levels
☐Improve concentration ☐Exercise routines to perform at home ☐Pediatric Care
☐Ergonomics/workspace Information ☐Diet advice & recommendations
☐Vitamins/supplements advice ☐Chiropractic Care for other family members
☐Chiropractic during Pregnancy
Other: ……...

4. LIFE STYLE

How would you rate your posture? ☐Good ☐Poor ☐Not sure

Do you exercise regularly? ☐Yes ☐No If yes, briefly describe:

Current exercise …….

Previous exercise ……

Hours spent sitting at a desk per day? ……

How much water do you drink per day? ……. litres or ……. Glasses

Do you wear ☐Heel lifts ☐Orthotics

5. CANCELLATION AND LATE ARRIVAL POLICY

Six (6) hours advance notice is required when cancelling an appointment, except in cases of illness, emergency or inclement weather. Cancellations within 6 hours notice will result in a charge of 50% of your session fee.
Please arrive on time for your appointment. If you arrive late, your session may be cut short or delayed. Full payment for your session is required at time of service.

6. CONSENT TO EXAMINATION AND TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when cracking knuckles and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or musculoskeletal acupuncture may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscular strain, ligament sprain, dislocations of joints, fractures or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as likely as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

The general benefits of treatment, possible contraindications and the treatment procedure have been explained to me. I understand that chiropractic adjustment may provide benefits for certain conditions but results are not guaranteed. I understand that the chiropractic care is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary medical practitioners for any condition I may have. I have informed the practitioner of all my known physical conditions, medical conditions and medications, and I will keep the practitioner updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the practitioner so the treatment can be adjusted.

I have read the above noted consent, cancellation and late arrival policy, and I have had the opportunity to question the contents and my proposed therapy. I understand that at any time I may withdraw my consent and treatment will be stopped.

If female, might you be pregnant? ☐Yes ☐No

…… ..……..…….

Patient's Signature (Parent or Guardian signature if patient is under 16)

……

Patient's Name (printed)

Dated: ……