

# CONFIDENTIAL CLIENT HISTORY

Mr/Mrs/Ms \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ P/code \_\_\_\_\_

Phone (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ (Mob) \_\_\_\_\_

Which number/s can we contact you on? (please tick) Hm  Wk  Mob

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Email (if appropriate to contact you) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Is this work related? Yes / No

Referred by:  Friend \_\_\_\_\_  Family  Yellow Pages  CAA

Do you wish us to advise your GP that you have consulted our clinic? Y/N if so please supply details

GP \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

Do you have "extras" health insurance? Yes / No Which company are you with? \_\_\_\_\_

Marital Status: S M D W Defacto Name \_\_\_\_\_ No. of children \_\_\_\_\_

Have you ever received Chiropractic care? Yes / No

Who is responsible for your account? \_\_\_\_\_ Signed \_\_\_\_\_

Is this a Workers Compensation claim? Yes / No Claim no: \_\_\_\_\_

Concession Card Holder Y/N No. \_\_\_\_\_

## **CURRENT CONCERNS**

Your reason for visiting us today: \_\_\_\_\_

When did this problem first begin? \_\_\_\_\_

What caused this complaint? \_\_\_\_\_

Have you had this problem before? Yes / No If yes, how often? \_\_\_\_\_

What treatment have you received for this complaint? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

## **HEALTH HISTORY**

- |  |   |
|--|---|
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Numbness in Fingers and/or Toes  |
| <input type="checkbox"/> Fever / Cold sweats           | <input type="checkbox"/> Change of bowel or bladder habit |
| <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Blurred Vision/ Double Vision    |
| <input type="checkbox"/> Confusion / Disorientation    | <input type="checkbox"/> Clumsiness                       |
| <input type="checkbox"/> Pain on coughing or straining | <input type="checkbox"/> Ears ringing / buzzing           |
| <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Chest pain                       |
| <input type="checkbox"/> Dizziness / Loss of balance   | <input type="checkbox"/> Do you drink alcohol?            |
| <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Do you smoke?                    |
| <input type="checkbox"/> Pins & Needles sensation      | <input type="checkbox"/> Use recreational drugs           |
| <input type="checkbox"/> Problems with blood pressure  | <input type="checkbox"/> Other health problems _____      |

Height \_\_\_\_\_

Weight \_\_\_\_\_

Are you on any medication? \_\_\_\_\_

Have you ever been involved in a motor vehicle accident? \_\_\_\_\_

Have you had any sporting or work-related injuries? \_\_\_\_\_

Any childhood injuries, falls or sickness? Y/N \_\_\_\_\_ Age \_\_\_\_\_

Have you had surgery or any organs removed or replaced? \_\_\_\_\_

What is your sleeping posture?  Side  Stomach  Back

### FAMILY HEALTH HISTORY:

	<u>Father's side</u>	<u>Mother's side</u>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Are you interested in symptomatic relief only Yes/No

An ongoing programme which involves both spinal care and improved health? Yes/No

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## INFORMED CONSENT TO CHIROPRACTIC CARE

Changes to the law now require all practitioners who adjust the spine to warn patients of material risks. In extremely rare circumstances, Chiropractic care of the neck may damage blood vessels and give rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). Whilst this has **never** occurred in this practice, we are still required to warn. If any adjustments are required you will be tested beforehand, as has always been our practise, i.e. check for dizziness, referred pain etc.

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 (less than 1 in 62,000).

Chiropractic adjustments of the spine are internationally recognised as being appropriate and far safer in dealing with neck and low back pain than medication and many other alternatives. – (A Risk Assessment of Cervical Manipulation, JMPT, 1994. Manga Report, Ontario Ministry of Health, 1993).

**I have discussed the above information with the Chiropractor and give my consent to Chiropractic Care.**

Client's name (*please print*): \_\_\_\_\_

Client's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Chiropractor's signature: \_\_\_\_\_

**FINANCIAL POLICY:**

*We require payment at the time of consultation.*

**PRIVACY STATEMENT:**

*The Chiropractic Domain does not provide your information to any third party.*