Confidential Patient Questionnaire

Mr/Miss/Mrs/Ms/Dr Surname: _____ Given Names: _____

Address: _____ Post code: _____

Occupation: _____ DOB: _____/_____/_____

Telephone: Home: _____ Mobile: _____ Work: _____

Name of Spouse: _____ Name(s) of Children: _____

Personal Email Address: _____

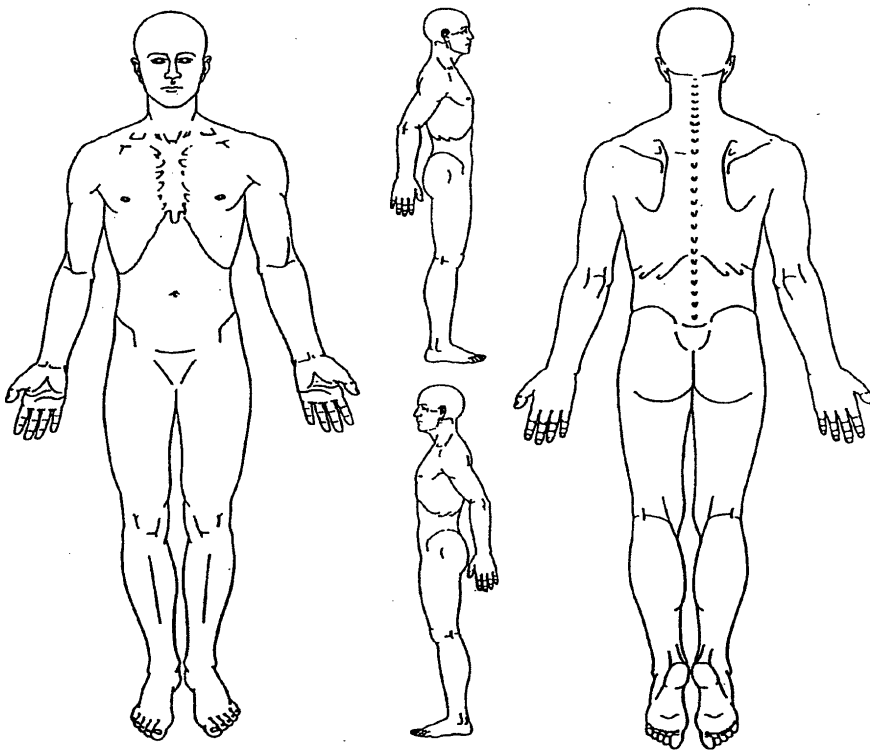
(Please Note: our primary source of correspondence with you will be by email, from The Spinal Centre.com.au)

Who can we thank for recommending you to us? _____

Please mark the entire area of your pain or problems on the diagram opposite

Use the letters below to indicate the location and extent of your problems.

P – Pain	S – Stiffness
A – Ache	B – Burning
N – Numbness	W – Weakness
H – Heat	C - Cold sensations
T - Tingling	X – Other sensations



Is this a work injury (WorkSafe)? _____

Is this TAC Claim? _____

What is your claim number? _____

Insurance Company? _____

List your major complaints.

1. _____
2. _____
3. _____
4. _____

Please list any other complaints or conditions.

1. _____
2. _____
3. _____
4. _____

List *every* fall, accident, motor vehicle accident, fracture or dislocation.

_____

_____

_____

Please list *all* surgical procedures and year.

_____

_____

_____

How did your major condition start or happen?

_____

How long have you had your major/main condition? Have you had this or similar in the past? When?

_____

Have you received any treatment for your main complaint(s)? What type? _____

_____

Do you have current (<1yr) X-rays, blood tests, CT scans or MRI's? _____

Who is your GP? Are you on any medications, painkillers, tranquillisers, contraceptive or other drugs?

_____

Have you ever been to a Chiropractor before? Who? When?

_____

Have you ever been to a Naturopath before? Who? When? Do you take any natural medicine, vitamins or herbs?

_____

_____

Have you had any Acupuncture or Chinese Medicine? Who? When?

_____

Do you smoke? _____ How many per day? _____

How much tea/coffee/coke/diet coke do you drink per day? _____

How much alcohol do you drink per day/week? _____

What activities would you like to be able to do when you regain your health? What are your Health Goals?

_____

_____

These questions apply to your health (considering your current complaint/condition).

How would you rate your overall health at this point? (Given or including your current complaint)

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Terrible **Great**

How would you rate the pain/discomfort levels you currently experience? (On an average day)

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain **Exceptional pain**

How would you rate the pain/discomfort levels on your worst day?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain **Exceptional pain**

Do your problems affect or interfere with day to day living activities?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Unable to function **No interference**

Do your problems affect your ability to carry out your work? If so to what level?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Unable to work **No problems**

Do your problems affect or interfere with necessities of life? (Sleep, eating, taking a shower etc.)

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Unable to function **No interference**

Do your problems affect or interfere with leisure or sporting activities?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Unable to function **No interference**

Have you experienced or had any of the following?

Past – Present	Past – Present	Past – Present	Past – Present
General health			
❑ ❑ General fatigue	❑ ❑ Poor Appetite	❑ ❑ Rashes	❑ ❑ Chills
❑ ❑ Fever	❑ ❑ Night sweats	❑ ❑ Spontaneous sweating	❑ ❑ Unexplained weight loss
❑ ❑ High blood pressure	❑ ❑ Low blood pressure	❑ ❑ Chest pains	❑ ❑ Irregular heart beat
❑ ❑ Cold hands	❑ ❑ Cold feet	❑ ❑ Swelling of hands	❑ ❑ Swelling of feet
❑ ❑ Insomnia	❑ ❑ Poor sleep	❑ ❑ Dream disturbed sleep	❑ ❑ Blurred vision
❑ ❑ Ulcerations	❑ ❑ Itching	❑ ❑ Eczema	❑ ❑ Loss of hair
Head, Neck and Lungs			
❑ ❑ Migraine	❑ ❑ Flashing lights in eyes	❑ ❑ Nausea/vomiting	❑ ❑ Eye pain
❑ ❑ Headaches	❑ ❑ Earaches	❑ ❑ Ringing in ears	❑ ❑ Poor hearing
❑ ❑ Sinus or hay fever	❑ ❑ Nasal congestion	❑ ❑ Postnasal drip	❑ ❑ Recurrent ear infections
❑ ❑ Sore throat	❑ ❑ Dry throat	❑ ❑ Strong thirst	❑ ❑ Bitter taste in mouth
❑ ❑ Facial pain	❑ ❑ Teeth problems	❑ ❑ Grinding teeth	❑ ❑ Clicking jaw
❑ ❑ Recurrent cough	❑ ❑ Coughing blood	❑ ❑ Asthma	❑ ❑ Bronchitis
Musculoskeletal			
❑ ❑ Neck pain	❑ ❑ Pain between shoulders	❑ ❑ Mid-back pain	❑ ❑ Lower back pain
❑ ❑ Shoulder pain	❑ ❑ Elbow pain	❑ ❑ Wrist pain	❑ ❑ Finger pain
❑ ❑ Hip pain	❑ ❑ Knee pain	❑ ❑ Leg pains	❑ ❑ Ankle pain
Gastrointestinal			
❑ ❑ Nausea	❑ ❑ Vomiting	❑ ❑ Diarrhoea	❑ ❑ Constipation
❑ ❑ Gas (flatulence)	❑ ❑ Belching	❑ ❑ Indigestion	❑ ❑ Abdominal pains/cramps
❑ ❑ Blood in stools	❑ ❑ Black stools	❑ ❑ Rectal pain	❑ ❑ Haemorrhoids
Reproductive			
❑ ❑ Pain on urination	❑ ❑ frequent urination	❑ ❑ Blood in urine	❑ ❑ Unable to hold urine
❑ ❑ Kidney stones	❑ ❑ Impotence	❑ ❑ Prostate problems	❑ ❑ Dribbling/burning urine
❑ ❑ Bed-wetting	❑ ❑ Testicular pains	❑ ❑ Sexual problems	❑ ❑ Pain on sexual activity
❑ ❑ Hot flushes	❑ ❑ Painful period's	❑ ❑ Irregular period's	❑ ❑ Heavy clotting on periods

Dietary – What would eat on a "normal" day? Please include tea, coffee and soft drinks etc.

Breakfast: _____

Morning Tea: _____

Lunch: _____

Afternoon Tea: _____

Dinner: _____

Supper: _____

Consent to Chiropractic Care and Natural Medicine

When performed by a registered Doctor of Chiropractic, Spinal Corrections and manipulation are an effective and safe method of treatment for many conditions.

The use of Natural Medicine and natural therapies including Massage, Acupuncture and Naturopathy are also safe and effective for the treatment of many conditions. However, you must be informed about the rare risks involved as with all health care procedures.

These risks include: muscle and joint soreness or strains, nausea, vomiting, stomach upsets, infections, rashes, dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation of an underlying condition.

Careful attention to the questions below will help us to ensure that these risks are minimised and the appropriate treatment is provided.

Health Screening: Have you ever been diagnosed, or experienced any of the following problems or conditions?

❑ Cancer	❑ Diabetes	❑ Heart disease/infection	❑ HIV or AIDS
❑ Are you pregnant?	❑ Arthritis	❑ Anaemia	❑ Required a heart pacemaker
❑ Stroke	❑ Hepatitis	❑ Blood disorders	❑ High Blood Pressure
❑ Epilepsy	❑ Collapsed lung	❑ Blood clotting problems	❑ Dizziness
❑ Pain waking you at night	❑ Pins & needles or numbness	❑ Pain on Coughing	❑ History of fainting or blackouts
❑ Knocked unconscious	❑ Pain with straining	❑ Pain on sneezing	❑ Any other serious illness

If yes, then please provide details:

_____

_____

_____

_____

If you have any further questions, please ask your practitioner during your consultation. You have the opportunity to discuss your proposed care with your practitioner and are encouraged to ask questions about the nature, extent and purpose of care that you need. You will have time to make an informed decision, giving consent for care to proceed.

I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed and I do not expect the practitioner to be able to anticipate all potential risks and possible complications associated with my proposed care.

I hereby acknowledge my consent to the performance of Chiropractic care, Rehabilitation, Massage, Acupuncture and Natural Medicine by my Practitioner.

Your Name (print) _____

Your Signature_____ Date: _____

(Parent of Guardian to sign if under 18)

Practitioner _____ Date: _____