Northside Chiropractic Clinic

PATIENT INFORMATION
STRICTLY CONFIDENTIAL

In order to provide a high standard of treatment the following information is needed and will be handled confidentially.

Date: ____/____/____

TITLE: ☐ Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other: _____

GIVEN NAME/s: _____

SURNAME: _____ DOB: ____/____/____

ADDRESS:

Private: _____

TELEPHONE: Phone _____ Mobile _____

E-mail: _____

PREFERED METHOD OF CONTACT: ☐ Ph (Pri) ☐ Ph (B) ☐ Ph (Mobile)
☐ E-Mail ☐ SMS ☐ Post

EMERGENCY CONTACT: Name: _____ Phone: _____

Relation: _____

PATIENTS MEDICAL DOCTOR: Name: _____

Address: _____

Phone: _____

Occupation/s: _____

SPORTS/HOBBIES: _____

ARE YOU COVERED BY ANY: ☐ Workers comp ☐ DVA ☐ GP referral (Medicare)

DO YOU HAVE PRIVATE HEALTH COVER: ☐ No ☐ Yes

How did you hear about Northside Chiropractic Clinic? _____

PATIENT HISTORY

What is your main purpose for today's appointment? _____

How long has the problem persisted? _____

What do you think is the cause? _____

Have you had any treatment for this problem? ☐ Yes ☐ No

If yes, with whom and when? _____

Have you had time off work due to this problem? ☐ Yes ☐ No

If yes how long and when? _____

Do you have any other symptoms/concerns? _____

Do your symptoms cause restrictions in your life? _____

What are you hoping to get from this consultation/treatment? _____

_____

Is there a family history of serious illness (cancer, diabetes, arthritis, etc)? ☐ Yes ☐ No

If yes please list: _____

Are you currently a smoker? ☐ Yes Number/day? _____ For how long? _____

☐ No If no have you smoked in the past? ☐ Yes ☐ No When did you stop? _____

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, when was your last visit?__/__/__ Were x-rays or other imaging taken? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No If yes, what to? _____

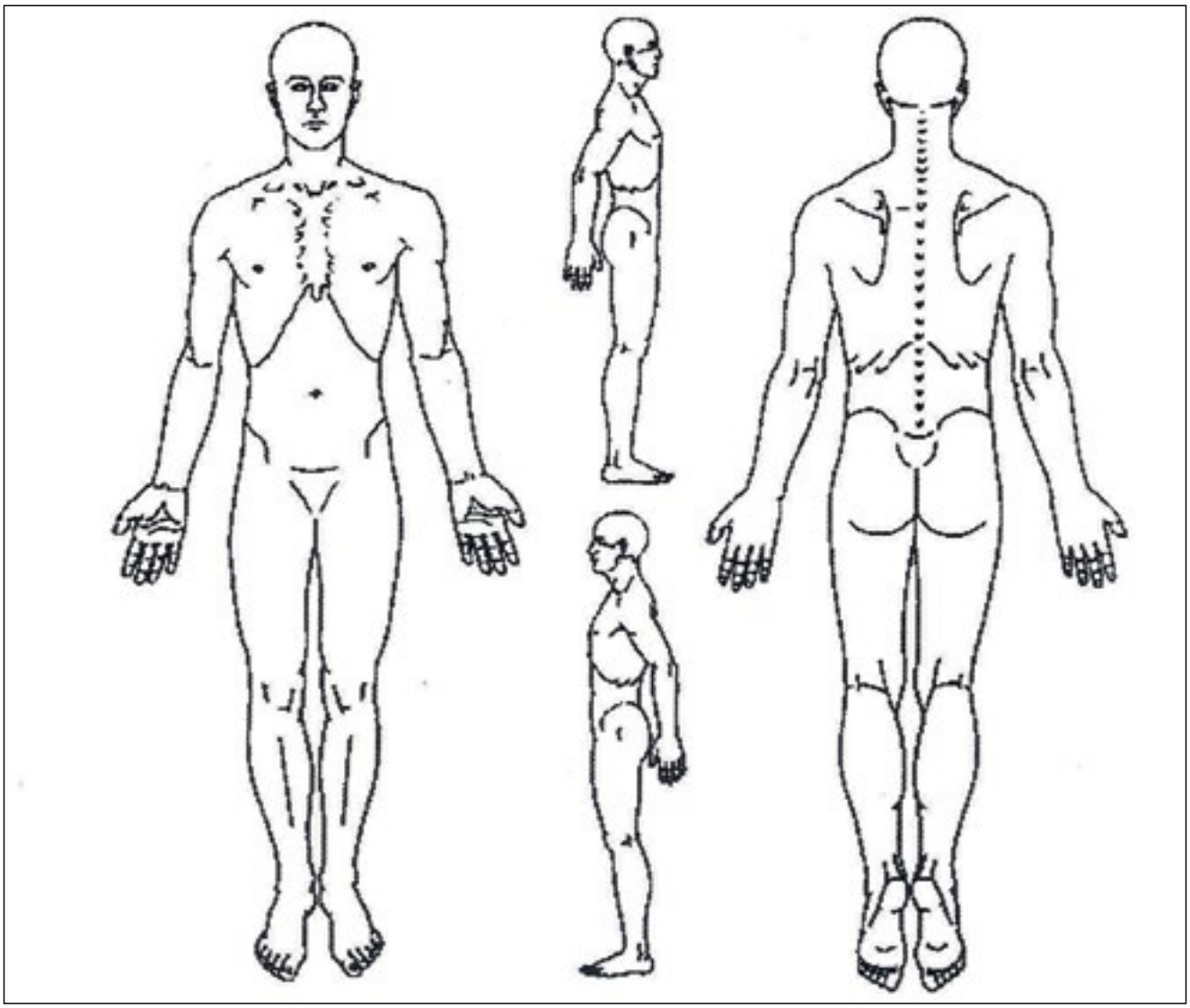
Have you had or do you have any of the following?

Medical Condition	Yes	No	Medical Condition	Yes	No
Headaches, Migraines	☐	☐	Diabetes	☐	☐
Eye problem, injury or disease. Visual disturbances	☐	☐	Liver Disease or dysfunction, Gail Bladder problems	☐	☐
Ear problems, hearing defects or disease	☐	☐	Muscle/Joint Problems e.g. Arthritis, Rheumatism Upper or Lower Limb Problems	☐	☐
Nose, Sinus, mouth, throat defects or disease	☐	☐	Back/neck problems of any description	☐	☐
Frequent sore throats, difficulty swallowing, Tonsillitis, Colds/Flu	☐	☐	Serious Injury or trauma e.g. concussion, falls, fractures, motor vehicle accident	☐	☐
Thyroid or other Gland problems	☐	☐	Injuries/deformities of the hand, foot or limbs which affect movement or normal use	☐	☐
Epilepsy, Frequent fainting attacks, Blackouts, Seizures, Dizziness or vertigo	☐	☐	Have you any physical disabilities that affect your mobility	☐	☐
Chest problems	☐	☐	Skin disease e.g. Dermatitis, Eczema	☐	☐
Heart disease, Chest Pain, Breathless	☐	☐	Numbness, Pins and needles, altered sensation in any region/area of body	☐	☐
Abnormal blood pressure	☐	☐	Infectious diseases (self or family) e.g. Hep B, AIDS, Tuberculosis, Chicken Pox, German Measles	☐	☐
Blood disorders	☐	☐	Psychiatric/Physiological disorders including: Anxiety, Depression, Eating disorders, drug/alcohol dependence, self harm	☐	☐
Stroke or stroke like symptoms	☐	☐	Cancer of any kind	☐	☐
Bladder or kidney problems	☐	☐	Other disorders not listed above:	☐	☐
Problems with Reproductive System	☐	☐	Current Medication:	☐	☐
Stomach or Bowel problems or Hernia					

PAIN DIAGRAM

How long have you had pain? _____ Years _____Months _____ Weeks
On the diagram below please indicate where you are experiencing pain or other symptoms right now.

A= Ache **B**= Burning **N**= Numbness
P= Pins & Needles **S** = Stabbing **X** = Stiffness



Please mark on the line below indicating your pain level.

No Pain _____ Worst Pain

Patient's Signature: _____ **Date**: _____

PATIENT INFORMATION

Please read the below information and do not sign the form until you have discussed any concerns with your Chiropractor.

All practitioners who manipulate the spine are required to warn patients of material risks associated with the procedures they apply. In very rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (estimated at between 1 in 2 million to 1 in 5.85 million neck manipulations. Haldeman, et al. Spine vol24-8 1999). Other very slight risks include strain/injury to a ligament or disc in the neck (less than I in 139,000) or the low back (l in 62,000) [Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2"d Ed.].

Some patients with bone weakening diseases may require techniques to be modified to avoid the rare possibility of rib or spine fracture.

The procedures to be used in your case will be described after which you will be asked if you have any questions. After speaking with the chiropractor we request that you sign below as your consent to proceed is required for both examination and treatment procedures.

Please note there may be a considerable degree of variation in individual patient response to the treatment and results are not guaranteed.

Print name:_____

Patient's signature:_____

Chiropractor's signature:_____

Date:_____

FINANCIAL POLICY: To assist us in reducing our administration costs, we would appreciate payment at the time of consultation. (Cash, credit card and EFTPOS are accepted here)