Living Well CHIROPRACTIC Coffs Harbour

HEALTH IN PARTNERSHIP

ADULT HISTORY QUESTIONNAIRE

Phone: 02 6651 3901

ACN: 163289405

Name _____

Date of Birth____/____/____ Occupation _____

Address _____

Suburb _____ Post Code _____

Ph (H) _____ (M) _____ (W) _____

Email _____

Emergency Contact_____No._____

Do you have a Centrelink health care card? Y / N

Marital Status _____Partner's Name _____

Children (names/ages) _____

Height (cm) _____ Weight (kg) _____

Currently pregnant? Y / N

Due date _____

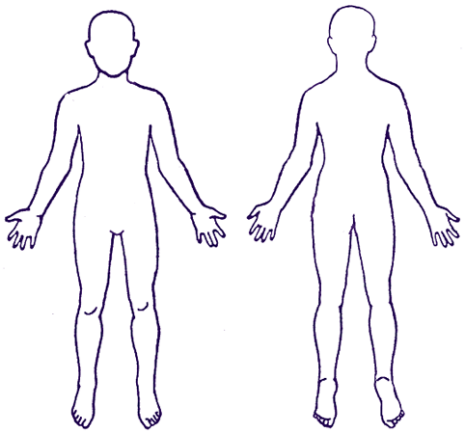
Received Chiropractic care before? Y / N

Name of Chiropractor _____

Date of last visit _____

Private health cover _____

Family Doctor _____



Please use the diagram to indicate any areas of concern

Who may we thank for referring you to this Practice?

_____

What is your main Area of Concern?

_____

_____

When did this problem start?

_____

Do you know what caused your problem?

_____

What makes it better? _____

What makes it worse? _____

How Frequent is it? (Please tick)

___Constant (100%)
___Increasing
___Frequent (> 50%)

Are Your Symptoms: (Please tick)

___Decreasing
___Occasional (25-49%)
___Not changing

Have you had any previous treatment for this problem? Y / N Did it work? Y / N

_____

How does this problem affect your life & work? (please tick as many as applicable)

- ☐ Moody
- ☐ Interrupted sleep
- ☐ Restricted with daily activities
- ☐ Poor decision making
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Lose patience with family members
- ☐ Interferes with ability to participate in leisure activities (e.g. hobbies, or sports, social life) Please list _____

_____

_____

Health History

Do you experience any of the following? (please tick as many as applicable)

___Fever
___Nausea
___Dizziness
___Neck Stiffness
___Night pain
___Excess Fatigue
___Migraines
___Visual changes
___Trouble talking
___Difficulty Breathing
___Headaches

Other than already mentioned, do you have or experienced any of the following symptoms or conditions?
(please tick as many as applicable)

___Low back pain
___Neck pain
___Changes in balance and coordination
___Changes in normal muscle strength
___Tension across top of the shoulders
___Ringing in ears
___Nausea
___Difficulty sleeping
___Arthritis
___Osteoporosis
___Anxiety/ Depression
___Skin problems
___Cholesterol problems
___Hormonal problems
___Heart condition
___Poor circulation
___High or low blood pressure
___Poor Digestion
___Weight changes
(recent gain or loss)
___Asthma or other respiratory problems
Allergies – if yes, please list
_____
_____

List any other major conditions (past or present)
_____

The care you will receive at this office will help you release tension from your spine, nervous system and body. Tensions build up due to physical, emotional and chemical stresses you experience. The following questions will help us to gain an understanding of the stresses you have experienced up until now.

Physical Stress

Please list all of the major physical traumas you have had (surgery, falls, car accidents, sporting injuries, broken bones, etc.) **along with the date they occurred. Please include any major falls, etc that may not have resulted in an injury at the time.**

_____
_____

Please list any positions you hold your body in for extended periods past or present. (e.g sitting at a computer, breast feeding etc.)

_____
_____

How do you grade your physical health?
__Excellent __Good __Fair __Poor __Terrible
Is it:
__Getting better __Not changing __Getting worse

Chemical Stress

Please list any current medications, reasons for taking them and when prescribed.

_____

_____

Past significant medications (Strong pain killers, anaesthetics, steroids, vaccination etc).

_____

_____

Have you been exposed to any major chemical toxins in your life? Y/N

If yes, please list _____

Do you now or have you ever smoked cigarettes?

☐ Yes ☐ No

Briefly describe your diet (meat and vegetables, vegetarian, artificial sweeteners, refined foods, health supplements/natural remedies).

_____

_____

How many cups of coffee/tea do you drink a day?

☐ 0 ☐ 1-2 ☐ 2-3 ☐ 4-7 ☐ 8+

How many glasses of water do you drink per day?

☐ 0 ☐ 1-2 ☐ 2-3 ☐ 4-7 ☐ 8+

How many glasses of alcohol do you drink per week on average?

☐ 0 ☐ 1-2 ☐ 2-3 ☐ 4-7 ☐ 8+

Emotional Stress

Please list any significant emotional stresses you have experienced from birth until now along with your age at the time. (eg family break ups, deaths, school or work stresses, change in lifestyle, abuse, traumatic events etc.)

_____

_____

Current emotional stresses (work, relationships, health concerns, financial, etc).

_____

_____

How do you grade your emotional/mental health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible

It is:

☐ Getting better ☐ Not changing ☐ Getting worse

Other Questions

What other types of treatment, past and present have you used for improving your health, healing or personal development? (eg doctor, physio, naturopath)

_____
_____

Is there anything else about your health or life circumstances that you think may be relevant?

_____
_____

What do you do to maintain good health? (eg exercise, diet, meditate)

_____
_____

There are five ways our patients use chiropractic care:

Relief care for their most obvious symptoms
Corrective care for their underlying problem
Maintenance care to sustain their progress
Preventative care to catch new problems early
Wellness care to be all that they can be
Be thinking of how far you want to take your care when you meet **Judith and Gillian.**

How important is your health to you?

☐ Not at all ☐ Somewhat ☐ Important ☐ Very Important

☐ My top Priority

All practitioners who adjust the spine are now required to warn of risks pertaining to spinal adjustments. In extremely rare circumstances (less than 1 in 5.85 million Haldeman, et al. Spine vol 24-8 1999) some spinal adjustments of the neck may damage a blood vessel and give rise to stroke like symptoms. Whilst this has never occurred in this practice we are still required to warn. Other very slight risks with care include muscle strains and sprains and disc injuries. With these incidents full recovery is expected. Tests with or without x-rays will be performed to further minimise risk.

"The best evidence indicated that cervical manipulation for neck pain is much safer that the use of medication (non steroidal anti-inflammatory drugs) by as much as a factor of several hundred times" Dabbs and Lauretti JMPT Oct 1995. (Journal of manipulative physical therapies)

I have read the above statement and consent to chiropractic care.

Signed_____ Date_____/_____/_____

Chiropractor's signed_____ Date_____/_____/_____

Thank you for your time and patience filling out your health questionnaire