BALLARAT Spinal Health
A Gonstead Chiropractic Centre

PATIENT HEALTH QUESTIONNAIRE

The information on this form is and will remain strictly confidential.

Please read the following sections carefully and write your answer / tick where appropriate.

PATIENT DETAILS

Patient's Name:_____ M / F Date of Birth:___/____/_____ Age:_____
Address:_____
City:_____ State:_____ Postcode:_____
Telephone (Home):_____ Telephone (Mobile):_____
Telephone (Work):_____ Email:_____
Occupation:_____

Whom can we thank for referring you to this Chiropractic Office?_____
Are you a member of a Private Health Fund that covers Chiropractic Care? ◯ YES ◯ NO
Do you currently have a WorkCover, TAC or DVA claim for this complaint? ◯ YES ◯ NO

PRESENTING COMPLAINT

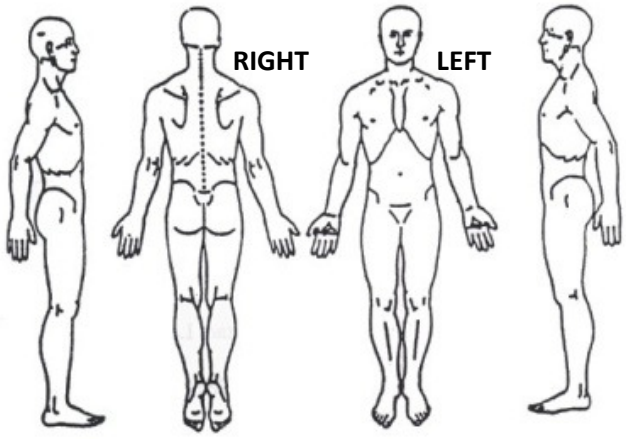
What is your major complaint?_____
Date problem began?_____
How did this problem begin (eg. falling, lifting)?_____
How is your problem changing? ◯ Getting Better ◯ Getting Worse ◯ Not Changing
Have you had this problem in the past? ◯ YES ◯ NO
Is this problem interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine
How often do you experience your symptoms? eg. 76-100% of the day
◯ Constant (76-100%) ◯ Frequent (51-75%) ◯ Occasional (26-50%) ◯ Intermittent (0-25%)
Describe the nature of your symptoms:
◯ Sharp ◯ Dull / Ache ◯ Throbbing ◯ Numbness ◯ Burning ◯ Tingling ◯ Shooting
◯ Stabbing ◯ Radiating ◯ Tightness ◯ Stiffness ◯ Other:_____

Please rate your discomfort or symptoms on a scale out of 10 (where 0 = no pain and 10 = excruciating pain):
CURRENTLY: /10 AT IT'S WORST: /10 AT IT'S BEST: /10

What aggravates your condition? (eg. working, exercise)_____
What relieves your condition? (eg. Exercise/stretching, heat/ice, massage)_____
List previous care you have received for this condition:_____
Do you have any other complaints? ◯ YES ◯ NO Describe:_____

What are your current health goals in presenting for Chiropractic care?
1. ◯ Emergency / Relief Care (eg. Pain Relief Only)
2. ◯ Corrective Care / Spinal Rehabilitation (eg. As per 1 above - PLUS Longer term stability and Prevention)
3. ◯ Support / Preventative Care (eg. As per 1 & 2 above - PLUS Lifestyle Changes / Modifications)

Please indicate the location of your pain / discomfort on this diagram:



PAST MEDICAL HISTORY (please tick where appropriate)

Have you had any recent Infections or immunisations? If so, what:_____

List any surgeries you have had and the year they were performed:

◯ Neck ◯ Back ◯ Shoulder ◯ Elbow ◯ Wrist ◯ Hand ◯ Foot
◯ Hip ◯ Knee ◯ Brain ◯ Neurological ◯ Other:_____

Have you been Hospitalised recently? ◯ YES ◯ NO If YES, why:_____
Have you ever been in a Motor Vehicle Accident? ◯ YES ◯ NO

Type_____When_____
Type_____When_____

List any traumas/injuries/falls you have sustained:

Type_____When_____
Type_____When_____

List any recent illnesses you have had:

Illness_____When_____
Illness_____When_____

Please tick those that apply to you (answers should be based on an average):

Do you Smoke?	◯ YES	◯ NO - How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Alcohol?	◯ YES	◯ NO - How many drinks per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Caffeine?	◯ YES	◯ NO - How many drinks per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Soft Drink?	◯ YES	◯ NO - How many drinks per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Water?	◯ YES	◯ NO - How many glasses per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you Exercise?	◯ YES	◯ NO - What forms and how often?_____				

_____

Do you have any Allergies? ◯ YES ◯ NO Describe:_____

_____

Please list any current medications you are taking / using (including contraceptive medication) and dosages if known:

_____

_____

Please list any current nutritional supplements you are taking (i.e. vitamins, minerals, herbs):

_____

List all family members who had/has any of these problems (eg. Grandmother – Bowel Cancer)

_____◯ Arthritis OR Auto-Immune Diseases (eg. Asthma, Rheumatoid Arthritis, Psoriasis)
_____◯ Blood Disorders (eg. High Blood Pressure, Cardiovascular Disease, Other Blood Diseases)
_____◯ Cancer
_____◯ Diabetes
_____◯ Epilepsy, Seizures OR other Neurological Conditions (eg. MS, Parkinson's)
_____◯ Genetic Disorders or Genetic Spinal Conditions (eg. Down's Syndrome, Cerebral Palsy)
_____◯ Fatalities (eg. Stroke, Heart Attack)

CHIROPRACTIC HISTORY

Have you had previous Chiropractic care? ◯ YES ◯ NO If Yes, what is their name?_____
Where are / were they located?_____ When was your last visit / treatment?_____
Were X-Rays taken? ◯ YES ◯ NO If Yes, when?_____
Was your previous Chiropractor a Gonstead practitioner? ◯ YES ◯ NO ◯ NOT SURE
What were the results of your previous treatment? ◯ Excellent ◯ Satisfactory ◯ Fair ◯ Did Not Help ◯ Got Worse

I declare that the above information is true and correct at the time of completion. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered (including where covered by WorkSafe and the Transport Accident Commission [TAC], even if liability for my claim is denied).

_____ / ____ / _____

Patient Name (Printed) **Patient Signature** **Date**

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

MUSCULOSKELETAL
- ◯ Neck or Back Pain
- ◯ Hip, Knee, Ankle or Foot Pain
- ◯ Shoulder, Elbow, Wrist or Hand Pain
- ◯ Swollen Joints
- ◯ Arthritis
- ◯ Weakness or Loss of Strength

EYES
- ◯ Vision Changes / Blurring / Double Vision
- ◯ Glasses / Contacts
- ◯ Dry / Watery
- ◯ Eye Pain
- ◯ Redness

EARS
- ◯ Hearing loss
- ◯ Tinnitus (Ringing), Buzzing
- ◯ Vertigo
- ◯ Pain
- ◯ Infection
- ◯ Slurred or other speech problems

NOSE
- ◯ Discharge
- ◯ Pain
- ◯ Difficulty Smelling things
- ◯ Frequent Colds / Sinusitis
- ◯ Stuffiness
- ◯ Hay Fever
- ◯ Nose Bleeds

NEUROLOGICAL
- ◯ Loss of Consciousness / Fainting / Blackouts / Seizures
- ◯ Sensory Loss / Tingling / Numbness / Weakness
- ◯ Wasting
- ◯ Headaches
- ◯ Memory problems
- ◯ Dizziness / Vertigo / Spinning
- ◯ Tremors
- ◯ Reduced Coordination
- ◯ Balance problems
- ◯ Head Injury
- ◯ Lumps or Swollen Glands

RESPIRATORY
- ◯ Chronic Cough
- ◯ Chest Pain
- ◯ Spitting up Phlegm or Blood
- ◯ Asthma or Wheezing
- ◯ Difficulty Breathing
- ◯ Tuberculosis

ENDOCRINE
- ◯ Thyroid Problems
- ◯ Heat / Cold Intolerance
- ◯ Unexplained or Weight Gain / Loss
- ◯ Excessive Thirst

CARDIOVASCULAR
- ◯ Chest Pain
- ◯ Heart illness / Arrhythmias / Irregularities
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Blood Disorder
- ◯ Poor Circulation
- ◯ Swelling in limbs
- ◯ Varicose Veins
- ◯ Cold Hands / Feet
- ◯ Stroke
- ◯ Anaemia

MOUTH
- ◯ Pain
- ◯ Swelling
- ◯ Dryness
- ◯ Toothaches
- ◯ Bleeding Gums, Tongue / Lips

THROAT
- ◯ Infections / Sore Throat
- ◯ Bad Breath
- ◯ Difficulty Swallowing
- ◯ Swollen Glands

GASTRO-INTESTINAL
- ◯ Poor Appetite / Excessive Hunger
- ◯ Pain over the abdomen
- ◯ Difficulty Swallowing
- ◯ Nausea
- ◯ Ulcers
- ◯ Heartburn / Indigestion
- ◯ Vomiting (blood?)
- ◯ Excess Wind (Belching or Flatulence)
- ◯ Bowel Irregularity (Incontinence?)
- ◯ Food Intolerance
- ◯ Blood in Stools
- ◯ Diarrhoea / Constipation
- ◯ Haemorrhoids (piles)
- ◯ Jaundice / Anaemia
- ◯ Chronic Fatigue

GENITO-URINARY (General)
- ◯ Bed Wetting
- ◯ Kidney Infections
- ◯ Frequent Urination
- ◯ Difficulty Urinating
- ◯ Incontinence
- ◯ Blood in Urine
- ◯ Burning with Urination
- ◯ Excessive Urination at night
- ◯ Prostate troubles
- ◯ Discharge

GENITO-URINARY (Females Only)
- ◯ Cramps or Back pain
- ◯ Painful Menstruation
- ◯ Irregular Menstruation
- ◯ Absence of Menstruation
- ◯ Hot Flashes
- ◯ Excessive Flow
- ◯ Vaginal discharge
- ◯ Swollen Breast
- ◯ Lumps in Breasts
- ◯ Discharge
- ◯ Pregnant
- ◯ Difficulty Conceiving

SKIN
- ◯ Eczema
- ◯ Psoriasis
- ◯ Lumps / Bumps / Swelling
- ◯ Bruise easily
- ◯ Mole Changes
- ◯ Rashes and/or Itching
- ◯ Acne
- ◯ Dryness
- ◯ Colour changes
- ◯ Temperature changes

PSYCHOLOGICAL

◯ Stress ◯ Anxiety ◯ Depression
◯ Nervousness ◯ Difficulty Coping ◯ Counselling?

OTHER HEALTH PROBLEM:

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INFORMED CONSENT TO CHIROPRACTIC CARE

The information on this form is and will remain strictly confidential.

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully

1. I acknowledge that I have discussed with my Chiropractor, the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."*
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.
   Details:_____
   _____
3. I have had the opportunity to discuss the proposed care with my Chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed Chiropractic care by my Chiropractor and/or any other Chiropractor working in this clinic. I understand that I can withdraw consent at any time.
7. I give this clinic permission to use my postal address to send me birthday cards and thank you cards. I also give permission for my children who are under Chiropractic care to have their photograph displayed in this clinic, if the child desires.

_____ _____

Patient Name (Printed) Patient Signature
(Parent or Guardian must sign if patient under 18years of age)

_____ _____

Chiropractor Name (Witness) Chiropractor Signature

____ / ____ / _____
Date

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