MyChiro ON PRESTON

Patient Case History

YOUR DETAILS

Name: Title _____ First name _____ Surname _____

Gender: ☐ Male ☐ Female Date of birth: ___ ___ / ___ ___ / ___ ___

Address: _____
Street # *Street Name* *Suburb* *PCode*

Contact details:
Home PH: _____
Mobile PH: _____
Work PH: _____
E-mail: _____

Preferred method of contact number:
☐ home
☐ mobile
☐ work

Are you a member of a private health fund?
☐ No ☐ Yes - Fund Provider: _____

Do you benefit from a Medicare Enhanced Primary Care Plan or Veteran's Affairs?
☐ No ☐ Yes

Is your chiropractic care covered by Workers compensation or ICWA (motor vehicle insurance)?
☐ No ☐ Yes (Please present your referral form to us)

Occupation: _____

If retired or unemployed, your previous occupation: _____

How did you find out about our clinic?
☐ Friend or Acquaintance _____
☐ Another Health Professional (please specify): _____
☐ Our Signage
☐ Family member
☐ Yellow Pages ○ *Online* ○ *Print*
☐ Website
☐ Advertising
☐ Facebook
☐ Location
☐ Natural Therapy Pages
☐ Other (please specify): _____

Have you received chiropractic care before? ☐ No ☐ Yes - If yes, when was your last visit? _____
Were you pleased with the service provided? _____

Have you ever had any spinal X-rays taken? ☐ No ☐ Yes - When? ___ ___ / ___ ___ / ___ ___
which spinal areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

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YOUR HEALTH OBJECTIVES

People consult this office with one or more of the following health objectives, please indicate which apply to you:

- ☐ For relief of my symptoms only
- ☐ For correction of the underlying causes of my symptoms and health problems
- ☐ To prevent the development of symptoms, health problems and degeneration
- ☐ To achieve an optimal level of health and well-being
- ☐ To improve and correct my poor posture

PRESENT STATE OF HEALTH

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed. People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major symptom/problem: _____

Pain / Problem started on: _____ triggered by: _____

Have you had previous episodes of this problem? ☐ No ☐ Yes - Number of times: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is the pain referring to other areas of your body? ☐ No ☐ Yes - Where? _____

Is condition getting worse? ☐ No ☐ Yes

What aggravates, brings on your condition or makes it worse? _____

What lessens, relieves your condition or makes it feel better? _____

Is this symptom/condition interfering with: ☐ Work ☐ Sleep ☐ Routine

☐ Other (please specify) _____

Have you seen other Doctors/Practitioners seen for this condition? ☐ No ☐ Yes

If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other

Please list any home remedies employed: _____

DAILY ACTIVITIES

Do your daily activities involve:

☐ heavy lifting	☐ computer work	☐ driving
☐ manual work	☐ repetitive tasks	☐ standing
☐ phone use	☐ emotional stress	

Do you read for prolonged periods? ☐ No ☐ Yes

Do you wear: ☐ dentures / a plate ☐ glasses or bifocals ☐ contact lenses

Please describe your sleeping posture: ☐ side ☐ back ☐ stomach

Sports you play or used to play:

_____	☐ currently play	☐ used to play
_____	☐ currently play	☐ used to play
_____	☐ currently play	☐ used to play
_____	☐ currently play	☐ used to play

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Are you trying to:	☐ Gain weight	☐ Lose weight	☐ Neither
Do you exercise?	☐ Daily to weekly	☐ Occasionally	☐ Never
Do you smoke?	☐ No	☐ Yes	
Do you sleep well?	☐ No	☐ Yes	

With regard to any medications you are currently on or have recently used, please list:

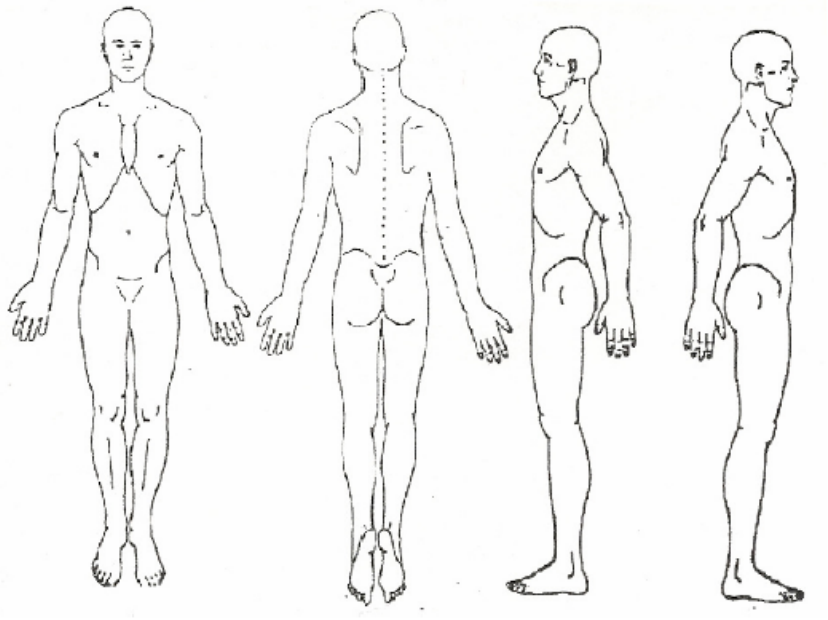
Drug/medication Names	Dosage	Reasons for use

Do you/ Have you ever suffered from the following:

☐ Stroke	☐ Loss of Vision	☐ Double Vision	☐ Cancer/Malignancy
☐ Dizziness	☐ Fainting	☐ Numbness in the Face	☐ Slurred Speech
☐ DVT (Deep Vein Thrombosis)	☐ Rheumatoid Arthritis	☐ Spondylolisthesis	☐ Constant Night Pain
☐ Ligament Rupture/Instability	☐ Spinal Trauma	☐ Nausea	☐ Bone/Joint Infection
☐ Difficulty Swallowing	☐ Frequent Headaches	☐ Ankylosing Spondylitis	☐ Loss of Bowel or Bladder Control
☐ Spinal Surgery	☐ Spinal Hypermobility	☐ Psoriasis	☐ Unexplained Weight Loss
☐ Heart Disease/Angina	☐ Numbness in Hands or Feet	☐ Osteoarthritis	
☐ Spinal Fracture	☐ Scoliosis	☐ Aneurysm	
☐ Osteoporosis	☐ Pin and Needles	☐ Dislocations	
☐ Swollen Joints	☐ Diabetes	☐ Frequent Colds	
☐ Asthma	☐ Severe Sudden Headache	☐ Other:_____	

Have you ever taken blood thinning medication such as Warfarin? ☐ No ☐ Yes

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -



19 Preston Street, Como WA 6152
Ph: 08 6161 5933 www.mychiroonpreston.com.au

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PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence.
However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Patient's Signature: _____

Date: _____

PATIENT INFORMATION

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatment of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. (Current literature states this to be approximately 1 in 1-2 million according to D. Chapman-Smith, seminar 2002 and approximately 1 in 5.85 million neck manipulations according to Haldeman, et al, Spine vol. 24-8 1999).

Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000).

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993).

Please note that this consent does not waiver your Common Law Rights, rather it is merely for you to acknowledge that you have been informed of the known risks.

If you have any questions related to the treatment you are about to receive or possible alternative approaches, please speak to the chiropractor.

I have discussed the above information with the chiropractor and give my consent to treatment.

Patient's Signature: _____ Print Name _____

Chiropractor's Signature _____ Date _____

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