CASE HISTORY

Name: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Phone (H) _____ (W) _____ (M) _____

Email address: _____

Would you like to register for online booking? Y N

☐ Please tick if you *do not* wish to receive a confirmation SMS prior to your appointment.

☐ Please tick if you *do not* wish to receive our newsletter

Occupation: _____ Employer: _____

Marital status: S M D W Name of children/ages: _____

Next of Kin: _____ Relationship: _____ Contact number: _____

How did you find out about our practice? Yellow Pages Online Yellow Pages Phonebook Google

Wellspring website Facebook Other: _____

Who may we thank for referring you? _____

Have you ever received Chiropractic care? Yes No Chiropractors name: _____

Are you covered for extras under a health fund? Yes No Health Fund: _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

Please circle for each of the following:		Client comment if answer is yes	Chiropractor's comments
REGARDING YOUR BIRTH PROCESS			
Was the delivery long/difficult?	Y N		
Forceps or extraction used?	Y N		
Cesarean/C-Section?	Y N		
Breach/cephalic	Y N		
Other? (induced labor, home birth)	Y N		
REGARDING YOUR GROWTH & DEVELOPMENT/CHILDHOOD			
Were you breast fed?	Y N		
Were you taught how to care for your spine?	Y N		
Childhood illnesses?	Y N		
Ear Infections/Colic/Asthma?	Y N		
Attention Deficit?	Y N		
Did you fall down stairs?	Y N		
Chair pulled out when sat down?	Y N		
Did you play any contact sports?	Y N		
Did you have any other childhood traumas?	Y N		

CURRENT HEALTH HABITS

Have you been involved in any accidents or traumas? Date? Injuries? Y N _____ _____

Did you ever break/fracture any bones? Y N _____ _____

Dental problems? Y N _____ _____

Eye problems? Y N _____ _____

Hearing problems? Y N _____ _____

Did/do you smoke? Amount? Years? Y N _____ _____

Did/do you drink alcohol? Y N _____ _____

Do you eat healthy foods? Y N _____ _____

Do you drink 8 glasses of water per day? Y N _____ _____

Exercise regularly? Y N _____ _____

Hobbies/sports injuries? Y N _____ _____

Did/do you have occupational stress? Y N _____ _____

Physical stress? Y N _____ _____

Emotional/mental stress Y N _____ _____

Do you sleep well? Y N _____ _____

Sleeping posture? O side O back O stomach

What type & how many pillows do you sleep on? _____

Do you have a good mattress? Y N _____ _____

How would you currently rate your health (if 10 is exceptional and 1 is poor)?

1 2 3 4 5 6 7 8 9 10

WHAT ARE YOUR HEALTH GOALS THROUGH CHIROPRACTIC?

O Relief of symptoms

O Prevention and relief of symptoms

O Overall improvement of your total health and wellbeing

SYMPTOMS AND PRESENT STATE OF HEALTH

Previous years of unnoticed and/or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

PRESENT COMPLAINT/REASON FOR SEEKING CARE:

Major Complaint: _____

_____

Pain or Problem started on: _____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other _____

Does this pain shoot, radiate, or travel in your body? Where? _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day?

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Please circle how you feel: (no Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition? _____

Any home remedies? _____

Please mark any of the following that you have now or have experienced in the past:

O Allergies	O High Blood Pressure	O Numbness in Legs or Feet
O Asthma	O Irritability	O Pain Between Shoulders
O Cancer	O Joint Swelling	O Pain in Hands or Arms
O Chest Pains	O Lights Bother Eyes	O Pain in Legs or Feet
O Constipation	O Loss of Balance	O Painful Urination
O Depression	O Loss of Smell or Taste	O Shortness of Breath
O Diabetes	O Low Back Pain	O Shoulder Pain
O Diarrhea	O Memory Loss	O Sinus
O Dizziness	O Menstrual Cramps	O Sleeping Problems
O Fatigue	O Neck Pain	O Stomach Upset
O Fever	O Neck Stiff	O Stroke
O Headaches	O Nervousness	O Tension
O Heart Attack	O Numbness in Hands or Arms	O Weight Loss

Do you take any supplements/vitamins? Y N Type? _____

Have you been under medical care? Y N

What medications are you taking? _____

How long have you taken these medications? _____

Have you had surgery? Y N Type & date of surgery? _____

What side effects have you experienced from the drugs and surgery? _____

Females Only – Date last Menstrual Period began on _____

Are you possibly Pregnant? Y N What is your due date? _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other	
Fathers side	O	O	O	O	O	_____
Mother's side	O	O	O	O	O	_____

INFORMED CONSENT

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, including assessment and treatment, 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.
2. 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.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
4. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
5. 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.
6. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (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 (less than 1 in 139,000) and the low back (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."

If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to the chiropractor.

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

_____ _____

Client or Guardian's Signature Chiropractor's Signature

_____ _____

Client's Name Date

CONSENT FORM – COLLECTION OF INFORMATION

Wellspring Chiropractic needs to collect information about you for the primary purpose of providing quality treatment. In order to thoroughly assess, diagnose and treat you, we need to collect some personal information from you. If you do not provide this information, we may be unable to treat you. This information will also be used:

- For the administrative purposes of running the practice;
- For billing, either directly or through an insurer or compensation agency;
- Within the practice for handover if another practitioner provides you with care;
- To update your doctor, teacher, specialist, insurer, solicitor or employer on the progress of your care, where they are involved in the management of your health.

We do not disclose your personal information to overseas recipients.

Wellspring Chiropractic has a Privacy Policy that is available on request and in our reception area. The Policy provides guidelines on the collection, use, disclosure and security of your information. It also contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

I, _____, have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my examination and treatment progress.

I am aware that I can access my personal and treatment information on request in writing, and if necessary, correct information that I believe to be inaccurate.

I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.

I have been provided with or have been given an opportunity to obtain a copy of Wellspring Chiropractic's Privacy Policy.

Signed:_____ Date:_____