

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

1. 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 _____	_____

2. 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 _____	_____

3. 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? side back 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?

- Relief of symptoms
- Prevention and relief of symptoms
- 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: Sharp Dull/ Ache Constant Intermittent 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:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness in Legs or Feet |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pain Between Shoulders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Pain in Hands or Arms |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Pain in Legs or Feet |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Smell or Taste | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> 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	<input type="checkbox"/>	_____				
Mother's side	<input type="checkbox"/>	_____				

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