



## Personal Detail

**\*CONFIDENTIAL**

NAME: Dr/Mr/Mrs/Ms \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

PHONE HOME: \_\_\_\_\_ PHONE WORK: \_\_\_\_\_

MOBILE PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE (\_\_\_\_) OCCUPATION: \_\_\_\_\_

PARTNER'S NAME: \_\_\_\_\_ NO. OF CHILDREN: \_\_\_\_\_

How did you find us? (Please circle) Gazette, Journal, Times, Front Sign, Yellow pages – online or book?  
Google, Flyer, BNI, Website, Newsletters, referral

Who can we thank for referring you? \_\_\_\_\_

Who is your regular doctor (General Practitioner)? \_\_\_\_\_

Clinic name and location? \_\_\_\_\_

What Health fund do you belong to? \_\_\_\_\_ Does it cover chiropractic care? \_\_\_\_\_

Have you ever seen a Chiropractor before? Y or N

Chiropractor's name	When?	Did it help?

## Medical History & General Health

Are you currently taking *any* form of **medication**?

Medication Name	What do you take it for?	Medication Name	What do you take it for?
1.		3.	
2.		4.	

Have you or any of your family members suffered from any **serious or hereditary diseases**?

\_\_\_\_\_

List (incl. year) all **surgeries and hospitalisations**?

Surgery	Year	Surgery	Year



Have you had spinal x-rays taken? Y/N. If so, what date (approx.)?

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**STRESSORS**

Because accumulation of stresses affects our ability to heal, please list any of the following below.

Physical stress (Falls, accidents, work postures, etc.)

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Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc)

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Psychological or mental/emotional (work, relationships, finances, self-esteem, etc)

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**GENERAL SYSTEM REVIEW**

- |   |  |  |
|---|--|--|
| <p><b>Past Present</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Pins &amp; Needles or numbness of legs or feet or hands</li> <li><input type="checkbox"/> <input type="checkbox"/> Mid Back Pain/Tension</li> <li><input type="checkbox"/> <input type="checkbox"/> Pain in Ribs or Chest</li> <li><input type="checkbox"/> <input type="checkbox"/> Low Back Pain/Weakness/Stiffness</li> <li><input type="checkbox"/> <input type="checkbox"/> Hip Pain or Stiffness</li> <li><input type="checkbox"/> <input type="checkbox"/> Buttock Pain</li> <li><input type="checkbox"/> <input type="checkbox"/> Leg Pain</li> <li><input type="checkbox"/> <input type="checkbox"/> Leg/Muscle Cramps</li> <li><input type="checkbox"/> <input type="checkbox"/> Knee Trouble</li> <li><input type="checkbox"/> <input type="checkbox"/> Foot or Ankle Trouble</li> <li><input type="checkbox"/> <input type="checkbox"/> Fainting or Blackouts</li> <li><input type="checkbox"/> <input type="checkbox"/> Stroke (TIA)</li> <li><input type="checkbox"/> <input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure</li> <li><input type="checkbox"/> <input type="checkbox"/> Ear Disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Cholesterol Problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Are you PREGNANT?</li> </ul> | <p><b>Past Present</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Scalp Disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Skin Disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Regular Colds &amp; Flu</li> <li><input type="checkbox"/> <input type="checkbox"/> Soreness in Neck</li> <li><input type="checkbox"/> <input type="checkbox"/> Shoulder Pain/ Stiffness/Tension</li> <li><input type="checkbox"/> <input type="checkbox"/> Painful/Clicking Jaw</li> <li><input type="checkbox"/> <input type="checkbox"/> Arm/Elbow Pain</li> <li><input type="checkbox"/> <input type="checkbox"/> Loss of Grip</li> <li><input type="checkbox"/> <input type="checkbox"/> Wrist or Hand Pain</li> <li><input type="checkbox"/> <input type="checkbox"/> Cold Hands / Feet</li> <li><input type="checkbox"/> <input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> <input type="checkbox"/> Vision Disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Dizziness/Light-headed</li> <li><input type="checkbox"/> <input type="checkbox"/> Stomach pains</li> <li><input type="checkbox"/> <input type="checkbox"/> Loss of Smell or Taste</li> <li><input type="checkbox"/> <input type="checkbox"/> Drink Alcohol( / wk)</li> <li><input type="checkbox"/> <input type="checkbox"/> Pain on Straining/Coughing/Sneezing</li> </ul> | <p><b>Past Present</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> <input type="checkbox"/> Chronic Cough</li> <li><input type="checkbox"/> <input type="checkbox"/> Stomach Tension</li> <li><input type="checkbox"/> <input type="checkbox"/> Digestion issues <input type="checkbox"/></li> <li><input type="checkbox"/> <input type="checkbox"/> Nausea/ Vomiting</li> <li><input type="checkbox"/> <input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> <input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> <input type="checkbox"/> Diarrhoea</li> <li><input type="checkbox"/> <input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> <input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> <input type="checkbox"/> Menstrual issues</li> <li><input type="checkbox"/> <input type="checkbox"/> Urinary Problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Chest pains</li> <li><input type="checkbox"/> <input type="checkbox"/> Smoker (___/day)</li> <li><input type="checkbox"/> <input type="checkbox"/> Freq loose stools</li> <li><input type="checkbox"/> <input type="checkbox"/> Been Unconscious</li> <li><input type="checkbox"/> <input type="checkbox"/> Fatigue</li> </ul> |
|---|--|--|



**Addressing what brought you into this office:**

If you have no symptoms or complaints and are here for chiropractic wellness services, please skip below

**Complaint/concerns**

List your complaint ( <i>according to severity</i> )  <i>**List each separately</i>	When did this episode start?	Rate of severity: Mild = 1, Severe = 10	How did this complaint begin?	If you have had this before when?	% of time pain is present?	What makes this complaint worse? i.e. How is this effecting your life?	What other treatment have you had for this?
1.							
2.							
3.							
4.							

**Office use only**

- 1.
- 2.
- 3.
- 4.

OBS, ROM, ULN, LLN, Maignes, Cx Compress, Cx distract, Valsalva's, Kemps, SI Spring, SLR, Tinell's

Diagnosis/ DDx



**CONSENT FORM**

At the **Pakenham Chiropractic** we are firmly committed to safety and efficacy in clinical practice. Spinal manipulation is a complex clinical skill and should **only** be performed by a suitably qualified professional (i.e. Chiropractic degree or equivalent). We endeavour, through professional conferences, journals and continuing education, to maintain the highest standards of care. As part of a professional standard of care, we feel it is important to discuss **risk**.

In any clinical or medical procedure that deals with people there are inherent risks. Complications of spinal manipulation when performed correctly and appropriately are **extremely** low in comparison to any other form of treatment. There is a possibility (figures suggest one chance in two million) that spinal manipulation of the cervical spine (neck) may be associated with damage (major or minor) to the blood supply of the brain (stroke). As an indication of comparative risk there is an accepted figure of sudden death under general anaesthesia of one in ten thousand; death caused by prescription anti-inflammatory drugs is **3,300 times more likely** than spinal manipulation. Other risks associated with spinal manipulation may relate more specifically to your condition or aggravation to the spinal structures themselves such as the bones and ribs (a possibility of fracture) or the discs, ligaments or nerves. The purpose of our physical examination is to assess your condition with these things in mind so that we may choose the most appropriate technique for you. We believe that our expertise and experience enable us to provide the safest possible care. However, we would ask your co-operation in keeping us fully informed of your symptoms, past illnesses and any changes in your medical history including medications.

**OUR PRIVACY COMMITMENT:** All information provided to **Pakenham Chiropractic** is confidential and will only be used by and available to your practitioner. As part of our commitment to your wellbeing, we consider it important to keep your General Practitioner informed of your care and treatment at this clinic. We may therefore send an explanatory note or report to your GP.

I **do / do not** give consent for **Pakenham Chiropractic** to communicate with my doctor.

Comments .....

If you have **any** queries or concerns please feel free to discuss these with us at any time. I have read and understood the above, and that I may choose to have no treatment or alternate treatment for my condition. I hereby consent to chiropractic treatment at **Pakenham Chiropractic**. I understand that I may withdraw my consent at any stage. I have had the opportunity to discuss this consent form and proposed treatment with the chiropractor.

Signature .....

Date...../2011

Name (please print) .....

**OFFICE USE ONLY**  
**INITIAL**

**DVD**

**ACTIVATOR/ MANUAL**

**GENTLE**

Chiropractor Notes

**ROF**

**X-RAYS - Neck P LBP Cervico-genic HA's Postural abnorm Mid Tx P Hand pain from neck Scoliosis**

**SCHED**