FOOTSCRAY CHIROPRACTIC CLINIC
Established 1966

Chiropractic Case History

Date_____

WELCOME!

The purpose of our clinic is to relieve pain, restore health and improve quality of life in each patient we accept for care. To do this quickly and efficiently we must find the underlying cause of the health problem and also determine exactly what needs to be done to correct that problem. This is our responsibility with every patient regardless of how simple or complex your symptoms may be. The aim of chiropractic care is not to treat your symptoms, but to get to the cause of your problem and correct it properly; this is done through natural means, without the use of drugs or surgery. Doctors of chiropractic specialize in locating, analyzing and correcting vertebral subluxations. Vertebral subluxations are structural misalignments in the spine that create imbalance and put pressure on the nervous system. A vertebral subluxation causes interference with nerve messages between the brain and the body, creating "dis-ease" (a term use to denote the loss of body harmony). For us to properly understand YOUR health problem we need a complete history of your present symptoms. We also need information about your general overall health. This in-depth knowledge will help us to determine the type of care needed and give some indication as to what can be anticipated in your case. Please answer every question completely and to the best of your ability. By doing so we will not have to ask you a lot of questions about health problems that do not pertain to your case. If, after consultation and/or examination, we do not sincerely believe you will benefit from Chiropractic care, then we will not accept you as a patient. Thank you for your co-operation in completing this "Confidential Patient Case History".

Name_____ **Sex M F Date of Birth**_____ **Age**_____

Address_____**State**_____**Postcode**_____

Home Phone (___) _____**Work Phone** (___) _____**Mobile Phone** _____

( ) Circle Best Contact Number

Email_____ **Referred By**_____

Occupation_____**Employer**_____

Emergency Contact:

Name_____ Phone Number_____ Relationship _____

Private Health Insurance_____ **D.V.A** Yes No **TAC** Yes No **Work Cover** Yes No

Have you ever received Chiropractic Care? Yes No **If Yes: When, Where and for what purpose**_____

_____

1. **Primary reasons for seeking chiropractic care:**

   Primary reason:
   _____

   Secondary reason:
   _____

2. **Chief Complaint:** _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle the quality of the complaint/pain: Dull Aching Sharp Shooting Burning Throbbing Deep Nagging

Other_____

Dose this complaint/pain radiate or travel to any areas of your body? Yes No Where? _____

Do you have numbness or tingling in your body? Yes No Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint/pain present, how long does it last? _____

Does anything aggravate the complaint? _____ _____

Does anything make the complaint better? _____

Is the complaint inferring with daily activities? _____

3. Previous treatments, medications, surgery, x-rays or scans you've had for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses or surgeries you've had in your life: _____

_____

B. Previous accidents or injuries: _____

_____

C. Have you ever broken any bones? Yes No Which? _____

5. Current Medications and reasons for taking: _____

_____

6. Please tick if you have ever had any of the following diseases or conditions:

- ☐ Cancer
- ☐ Stroke
- ☐ Heart Complaint
- ☐ Asthma
- ☐ Headache
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Aneurysm
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Migraine
- ☐ Spinal disc injury
- ☐ High Blood Pressure
- ☐ Clotting Disorder
- ☐ Hernia
- ☐ Gout
- ☐ Sudden weight change
- ☐ Dizziness

Females: Are you pregnant? Yes No Unsure

7. Social & Occupational History

A. Job physical demands: _____

B. Recreational activities: _____

Patient Signature _____ **Date** _____/_____/_____

CONSENT TO CHIROPRACTIC CARE

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.

1. I acknowledge that I have discussed with Dr Jeremy Nicks/Dr Phillip Drysdale the rare risks associated with my proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition.
2. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
3. I have had the opportunity to discuss the proposed care with Dr Jeremy Nicks/Dr Philip Drysdale. 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 herby acknowledge my consent to the performance of the proposed chiropractic care by Dr Jeremy Nicks/Dr Phillip Drysdale and or any other chiropractor working in this clinic. I understand I can withdraw my consent at any time.

_____ _____ _____

Patient's Signature | Patient's Name (Printed) | Date

(Patient or Guardian to also sign if patient is under 18)