NEWCASTLE CHIROPRACTIC CLINIC
25 YEARS OF LOOKING AFTER THE HEALTH OF YOUR SPINE

CONFIDENTIAL PATIENT INFORMATION ***Welcome to our clinic!***

Please complete all questions and ***PRINT*** *clearly. All the information you provide remains confidential to this clinic* ***DATE*** …………………

Surname:		First Name:
Address:		Town:
		Post Code:
Home Phone:	Mobile Phone:	Work Phone:
Date of Birth:		Email:
Marital Status:		Partner's name:
Children's names and ages:		
Occupation:		Employed by:
How did you hear about the practice?		
Type of work: Sitting ☐ Computer ☐ Telephone ☐ Standing ☐ Driving ☐ Lifting ☐ Other _________		

Your current complaint

Please list your **chief complaints** in order of severity, Or tick here ☐ if your reason for attending is to **improve Health and Wellness**

1. ____When did **this episode** start? __________________
2. ____When did **this episode** start? __________________
3. ____When did **this episode** start? __________________

Have you ever had this pain before (or similar pain in the same area or even minor pain in the same area)? Yes ☐ No ☐

If YES, when was the **first time**? ________________ How many previous episodes have you had?____________

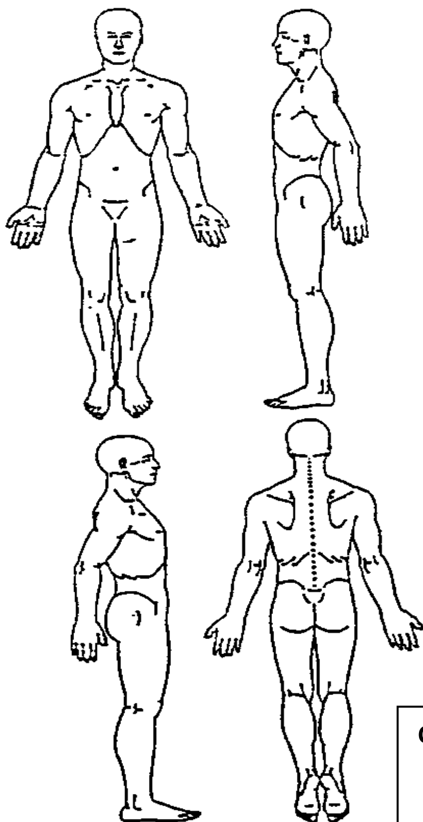
How did it happen? ____

Does the pain **spread** (arms, shoulders, buttocks, legs…)? ____

Rate the **severity** of your pain on a scale from 0 to 10: **No Pain** - 0 1 2 3 4 5 6 7 8 9 10 - **Unbearable Pain**

What percentage of the time is your pain present? **No pain** 0 10 20 30 40 50 60 70 80 90 100% **Constant Pain**

PLEASE MARK ON ALL PROBLEM AREAS ON THE DIAGRAM



Is the pain: Sharp Dull/Aching Shooting Burning Throbbing Numb/Tingling

Are the symptoms: Constant Come and Go Worse in the morning Worse in the evening

Is the problem: Progressively worse Progressively better Staying the same

What **aggravates** your symptoms? Coughing Sneezing Sitting Standing Walking Bending Lifting Turning head Lying Sleeping Other

What **relieves** your symptoms? Sitting Standing Walking Lying down Stretching Ice Heat Medication

What do you think is **wrong**? _____________________________

What do you think **caused** it? _____________________________

CLINIC USE ONLY – HISTORY and PREVIOUS EPISODES - PQRST

General history

Name and address of current GP: ____

Date of last physical: ______________ We may write to your GP about your condition. Is that ok? YES ☐ NO ☐

Please tick if you have had any of the following:

☐ Low back pain	☐ Anxiety/ Nervousness	☐ Hot flushes/ fevers	☐ Arthritis
☐ Neck pain	☐ Irritability	☐ Allergies	☐ Osteoporosis
☐ Headaches	☐ Depression	☐ Mood swings	☐ Heart disease
☐ Dizziness	☐ Low pain threshold	☐ Digestive problems	☐ Stroke
☐ Poor concentration	☐ Frequent Colds/infections	☐ Ulcers	☐ Diabetes
☐ Low energy / Fatigue	☐ Cold hands / feet	☐ Bladder problems	☐ Respiratory problems
☐ Seizures / Fainting	☐ High Blood Pressure	☐ Menstrual pain / Irregularity	☐ Cancer
☐ Migraines			☐ Skin disorders

Please list any **operations** you have had (and ages):

1. ______________________ 2. ______________________ 3. ______________________

Please list any serious **illnesses** you have had (and ages):

1. ______________________ 2. ______________________ 3. ______________________

Please list any **traumas**, car accidents, broken bones or injuries you have had (and ages):

1. ______________________ 2. ______________________ 3. ______________________

4. ______________________ 5. ______________________

Are you currently taking **medications** (including the contraceptive pill)? If yes, what type and what for?

____

Has anyone in your immediate family ever suffered from: Cancer, Hepatitis, Diabetes, Epilepsy, Tuberculosis,

Rheumatoid Arthritis or Vascular disease? Details ______________________________

Do you **smoke**? YES ☐ NO ☐ If YES, how many per day? _________ For how many years? _________

Do you **drink alcohol**? YES ☐ NO ☐ If YES, how many units per week? _____ For how many years? ______

Do you take part in any **regular exercise**? YES ☐ NO ☐ If YES, how often and what type? ____________________

What are your **Hobbies**: ____

Females only: Is there any possibility that you are **pregnant**? YES ☐ NO ☐ Date of last period: ______________

Do your mother, father, siblings or children have the **similar problems**? YES ☐ NO ☐ If YES, who? __________________

Have you ever been to a **chiropractor** before? YES ☐ NO ☐ If YES, when? ______________________________

Please list the **doctors or therapists** who were consulted for these conditions:

1. ________________________________ Diagnosis given______________________
2. ________________________________ Diagnosis given______________________
3. ________________________________ Diagnosis given______________________

CLINIC USE ONLY – PREVIOUS EPISODE CONTD.

General pain disability index

We would like to know how much your pain is preventing you from doing what you would normally do. Respond to each category indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE NUMBER EACH ACTIVITY WITH A SCORE OF 0-10 WHICH BEST DESCRIBES YOUR TYPICAL LEVEL. A score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain and a score of 0 means no limitation at all.

No limitation – 0 1 2 3 4 5 6 7 8 9 10 - Total limitation

1. Family/Home Responsibilities - Chores and duties performed around the house (eg. gardening, housework, shopping) ☐

2. Recreation - Hobbies, sports, and other similar leisure time activities. ☐

3. Social Activity-Participation with friends and family. Parties, theatre, concerts, dining out and other social functions. ☐

4. Occupation - Directly related to your job. Full, part, or non-paid positions; including homemaker. ☐

5. Self Care - Personal maintenance and independent daily living (eg. Taking a shower, driving, dressing, etc.) ☐

6. Life-Support Activity - Eating, sleeping, and breathing. ☐

General

Rate yourself for each of the following:

		CLINIC USE
How well do you **Sleep**?	Well 1 2 3 4 5 6 7 8 9 10 Hardly	
How are your **Energy** levels?	Excellent 1 2 3 4 5 6 7 8 9 10 Very Low	
How **Stressed** are you?	Not at all 1 2 3 4 5 6 7 8 9 10 Extremely	
How are you **Concentration** levels?	Excellent 1 2 3 4 5 6 7 8 9 10 Poor	
How good is your **Bowel Function**?	Very Good 1 2 3 4 5 6 7 8 9 10 Poor	
How has your pain affected your **Appetite?**	Not at all 1 2 3 4 5 6 7 8 9 10 Badly	
What is your **Mood** like?	Very good 1 2 3 4 5 6 7 8 9 10 Poor	
Does your **Immune System** function well?	Excellent 1 2 3 4 5 6 7 8 9 10 Poor	
How **Irritable** are you?	Not at all 1 2 3 4 5 6 7 8 9 10 Extremely	
How good do you think your **Posture** is?	Excellent 1 2 3 4 5 6 7 8 9 10 Poor	

Your Health Goals

- Are you happy with the way you feel? **Very Happy** 1 2 3 4 5 6 7 8 9 10 **Unhappy**
- How long has it been since you have felt your best? YEARS MONTHS DAYS
- How long have you been thinking about pursuing your health goals? YEARS MONTHS DAYS
- What are you most interested in improving? (You can circle more than one)
  Less Pain / Symptoms Reducing Stress Increasing Energy & Vitality Overall Health
- How long do you think it will take to achieve your health goals? YEARS MONTHS DAYS

What is the most important thing that your condition prevents you from doing? ______________________

Your spine and posture

- **Postural distortions** can run in families and people with similar activities. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problems? YES ☐ NO ☐
- **Spinal misalignments** can cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? YES ☐ NO ☐
- **A poorly functioning spine and nervous system** can affect your overall health. Does the problem affect your work or any sports/hobbies you enjoy? YES ☐ NO ☐
- **Poor posture** can lead to poor health and often indicates a spinal problem. How would you rate your posture?
  Excellent - 1 2 3 4 5 6 7 8 9 10 - **Poor**
- **Stress** can cause or accelerate spinal damage. Rate your stress level over the last 3 months:
  Low - 1 2 3 4 5 6 7 8 9 10 - **High**

DECLARATION: This information is true and accurate to the best of my knowledge.

Patient Signature: _______________________ Date: ____________

Informed consent

Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug-free health care profession in the world. Due to recent major world events and changes in the health and insurance industries, we want to inform you of the possible risks associated with chiropractic care.

1. You will be tested before any adjustments are applied.
2. Sometimes you may get pain, a strain to a ligament or disc, or an aggravation of the underlying condition from a perfect adjustment. This may happen just like a good massage or gym session. If this occurs please call us straight away, there are things that your practitioner can do to help.
3. If this occurs you may even require a 2nd adjustment. We never charge if you need a 2nd adjustment on the same day.
4. Adverse reactions to treatment are extremely rare and mild to moderate soreness after treatment can be experienced and part of the healing process.
5. Chiropractic adjustments of the spine are internationally recognised as being far safer than many medications and many other alternatives (further details provided on request).

I acknowledge the above information and do not expect the practitioner to be able to anticipate all potential risk and complications.

Based on all information provided, I consent to and look forward to receiving Chiropractic care at this practice.

______________________________________ ______________________________________

Patient Name Patient/Guardian signature

____

Practitioner Signature

Data Protection

Under the **Data Protection (1998) Act**, as a health service provider, we are required to advise our patient(s) of our Data Protection Policy and to obtain consent from the patient for the purpose of the consultation, examination and treatment. As part of the patient record, our clinic is required to retain information for the purpose of the consultation for treatment, recording subsequent treatments and for use by third party medical practitioners only, at the request of the patient in writing.

Information will be held both manually and electronically in files accessible only by the staff of the clinic who are directly involved in the data entry and processing of patient records (with the exception of employees and partners and owners of the practice). Information will be kept for as long as the patient remains a patient of the clinic and thereafter for a period of 8 years. All information provided will be treated as confidential and will not be given to any other person(s)/organisation(s) without the explicit consent of the patient concerned..

To keep you abreast of news, developments and activities at our office, you will be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities etc. Additionally, we may contact you in relation to your care. We require your permission to contact you, either by post, fax, email, telephone or otherwise.

PATIENT SIGNATURE ____ DATE: ____ / ____ / ______