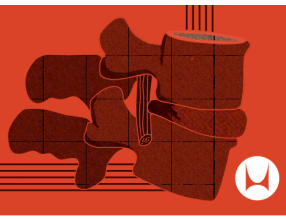
GONSTEAD CHIROPRACTOR
Hoyne Chiropractic . 0424 176 405



Chiropractic – patient health questionnaire

The information on this form is and will remain strictly confidential

Please read the following sections carefully and write your answer / tick where appropriate

PATIENT DETAILS

Patient's Name: _____ ☐M / ☐F Date of Birth: __/__/____ Age: _____
Address: _____
City: _____ State: _____ Postcode: _____
Telephone (Home): _____(Mobile): _____(Work): _____
Email: _____
Occupation: _____

Name of Doctor: _____
Telephone: _____

Is your family a member of a Private Health Fund that covers Chiropractic Care? ◯ YES ◯ NO
Name of your Fund: _____

Who referred you to this Chiropractic Office?: _____

Is this a Workers Compensation, Transport Accident, Department of Veterans Affairs case?
(eg. WorkCover, TAC, DVA)
◯ YES ◯ NO If YES, which? (Please include Claim number): _____

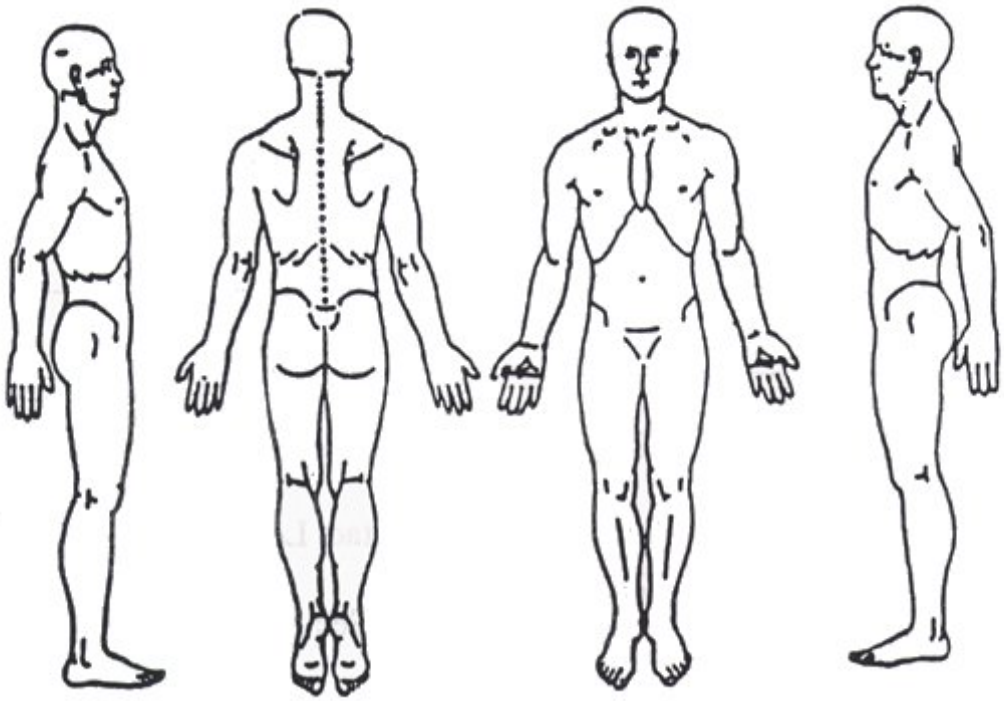
PRESENTING COMPLAINT

What is your major complaint? _____
Date problem began? _____
How did this problem begin (eg. falling, lifting)? _____
How is your problem changing? ◯ Getting Better ◯ Getting Worse ◯ Not Changing
Have you had this problem in the past? ◯ YES ◯ NO
Is this problem interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine
How often do you experience your symptoms? eg. 76-100% of the day
◯ Constant (76-100%) ◯ Frequent (51-75%) ◯ Occasional (26-50%) ◯ Intermittent (0-25%)
Describe the nature of your symptoms:
◯ Sharp ◯ Dull / Ache ◯ Throbbing ◯ Numbness ◯ Burning ◯ Tingling
◯ Shooting ◯ Stabbing ◯ Radiating ◯ Tightness ◯ Stiffness ◯
◯ Other: _____

Please rate your discomfort or symptoms on a scale out of 10 (where 0 = no pain and 10 = excruciating pain):
CURRENTLY: __/10
AT IT'S WORST:__/10
AT IT'S BEST:__/10

What aggravates your complaint? (eg. working, exercise) _____
What relieves your complaint? (eg. exercise, stretching, heat, ice, massage)_____
_____
_____
List previous care you have received for this complaint:
Do you have any other complaints? ◯ YES ◯ NO Describe: _____

Please indicate the location of your pain / discomfort on this diagram:



Right: **Left:**

PAST MEDICAL HISTORY (please tick where appropriate)

Have you had any recent Infections or immunisations? If so, what: _____

List any surgeries you have had and the year they were performed:

◯ Neck	◯ Back	◯ Shoulder	◯ Elbow	◯ Wrist	◯ Hand
◯ Foot	◯ Hip	◯ Knee	◯ Brain	◯ Neurological	◯

◯ Other: _____

Have you been hospitalised recently? ◯ YES ◯ NO

If YES, why: _____

Have you ever been in a Motor Vehicle Accident? ◯ YES ◯ NO

Type: _____

When: ___/___/_____

Type: _____

When: ___/___/_____

List the major traumas/injuries/falls you have sustained:

Type: _____

When: ___/___/_____

Type: _____

When: ___/___/_____

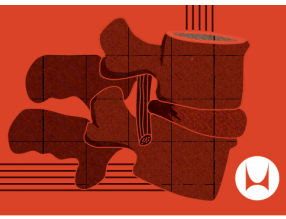
List any recent illnesses you have had:

Type: _____

When: ___/___/_____

Type: _____

When: ___/___/_____



Please tick those that apply to you (answers should be based on an average):

Do you Smoke?	◯ YES	◯ NO		
- How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Alcohol?	◯ YES	◯ NO		
- How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Caffeine?	◯ YES	◯ NO		
- How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Soft Drink?	◯ YES	◯ NO		
- How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you drink Water?	◯ YES	◯ NO		
- How many per day?	◯ 1-2	◯ 3-5	◯ 5-10	◯ 10+
Do you Exercise?	◯ YES	◯ NO		

- What forms and how often? _____

_____

Do you have any Allergies? ◯ YES ◯ NO Describe:

Please list any current medications you are taking / using (including contraceptive medication) and dosages if known: _____

_____

_____

Please list any current nutritional supplements you are taking (i.e. vitamins, minerals, herbs): ____

_____

_____

List all family members who had/has any of these problems (eg. Grandmother – Bowel Cancer)

_____ ◯ Arthritis OR Auto-Immune Diseases
(eg. Asthma, Rheumatoid Arthritis, Psoriasis)

_____ ◯ Blood Disorders
(eg. High Blood Pressure, Cardiovascular Disease, Other Blood Diseases)

_____ ◯ Cancer

_____ ◯ Diabetes

_____ ◯ Epilepsy, Seizures OR other Neurological Conditions
(eg. MS, Parkinson's)

_____ ◯ Genetic Disorders or Genetic Spinal Conditions
(eg. Down's Syndrome, Cerebral Palsy)

_____ ◯ Fatalities
(eg. Stroke, Heart Attack)

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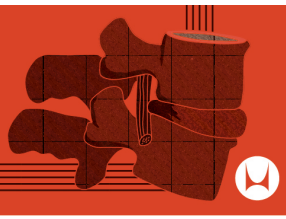

CHIROPRACTIC HISTORY

Have you had previous Chiropractic care? ○ YES ○ NO
If Yes, what is the name of your previous Chiropractor? : _____
Where are / were they located? : _____
When was the last visit / treatment? : _____
Were X-Rays taken? ○ YES ○ NO
If Yes, when?: ___/___/_____

Was the previous Chiropractor a Gonstead practitioner? ○ YES ○ NO ○ NOT SURE
What were the results of your previous treatment?
○ Excellent ○ Satisfactory ○ Fair ○ Did Not Help ○ Got Worse

I declare that the above information is true and correct at the time of completion. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

_____ _____
Patient Name (Printed) Patient Signature

Date: ___/___/_____

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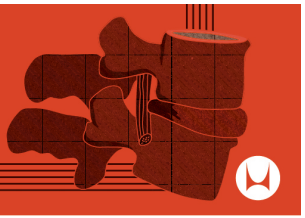

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

MUSCULOSKELETAL ◯ Neck Or Back Pain ◯ Hip, Knee, Ankle Or Foot Pain ◯ Shoulder, Elbow, Wrist Or Hand Pain ◯ Swollen Joints ◯ Arthritis ◯ Weakness Or Loss Of Strength	**EYES** ◯ Vision Changes / Blurring / Double Vision ◯ Glasses / Contacts ◯ Dry / Watery ◯ Eye Pain ◯ Redness	**EARS** ◯ Hearing Loss ◯ Tinnitus (Ringing), Buzzing ◯ Vertigo ◯ Pain ◯ Infection ◯ Slurred or other speech problems	**NOSE** ◯ Discharge ◯ Pain ◯ Difficulty Smelling Things ◯ Frequent Colds / Sinusitis ◯ Stuffiness ◯ Hay Fever ◯ Nose Bleeds
NEUROLOGICAL ◯ Loss Of Consciousness / Fainting / Blackouts / Seizures ◯ Sensory Loss / Tingling / Numbness / Weakness ◯ Wasting ◯ Headaches ◯ Memory Problems ◯ Dizziness / Vertigo / Spinning ◯ Tremors ◯ Reduced Coordination ◯ Balance Problems ◯ Head Injury ◯ Lumps Or Swollen Glands	**RESPIRATORY** ◯ Chronic Cough ◯ Chest Pain ◯ Spitting up Phlegm or Blood ◯ Asthma or Wheezing ◯ Difficulty Breathing ◯ Tuberculosis **ENDOCRINE** ◯ Thyroid Problems ◯ Heat / Cold Intolerance ◯ Unexplained Or Weight Gain / Loss ◯ Excessive Thirst	**CARDIOVASCULAR** ◯ Chest Pain ◯ Heart illness / Arrhythmias / egularities ◯ High Blood Pressure ◯ Low Blood Pressure ◯ Blood Disorder ◯ Poor Circulation ◯ Swelling in Limbs ◯ Varicose Veins ◯ Cold Hands / Feet ◯ Stroke ◯ Anaemia	**MOUTH** ◯ Pain ◯ Swelling ◯ Dryness ◯ Toothaches ◯ Bleeding Gums, Tongue / Lips **THROAT** ◯ Infections / Sore Throat ◯ Bad Breath ◯ Difficulty Swallowing ◯ Swollen Glands

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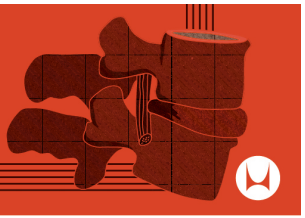

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

GASTRO-INTESTINAL
- ◯ Poor Appetite / Excessive Hunger
- ◯ Pain over the Abdomen
- ◯ Difficulty Swallowing
- ◯ Nausea
- ◯ Ulcers
- ◯ Heartburn / Indigestion
- ◯ Vomiting (blood?)
- ◯ Excess Wind (Belching or Flatulence)
- ◯ Bowel Irregularity (Incontinence?)
- ◯ Food Intolerance
- ◯ Blood in Stools
- ◯ Diarrhoea / Constipation
- ◯ Haemorrhoids (piles)
- ◯ Jaundice / Anaemia
- ◯ Chronic Fatigue

GENITO-URINARY (General)
- ◯ Bed Wetting
- ◯ Kidney Infections
- ◯ Frequent Urination
- ◯ Difficulty Urinating
- ◯ Incontinence
- ◯ Blood in Urine
- ◯ Burning with Urination
- ◯ Excessive Urination at night
- ◯ Prostate troubles
- ◯ Discharge

GENITO-URINARY (Females Only)
- ◯ Cramps or Back Pain
- ◯ Painful Menstruation
- ◯ Irregular Menstruation
- ◯ Absence of Menstruation
- ◯ Hot Flashes
- ◯ Excessive Flow
- ◯ Vaginal Discharge
- ◯ Swollen Breast
- ◯ Lumps in Breasts
- ◯ Discharge
- ◯ Pregnant
- ◯ Difficulty Conceiving

SKIN
- ◯ Eczema
- ◯ Psoriasis
- ◯ Lumps / Bumps / Swelling
- ◯ Bruise easily
- ◯ Mole Changes
- ◯ Rashes and/or Itching
- ◯ Acne
- ◯ Dryness
- ◯ Colour changes
- ◯ Temperature changes

PSYCHOLOGICAL
- ◯ Stress
- ◯ Nervousness
- ◯ Anxiety
- ◯ Difficulty Coping
- ◯ Depression
- ◯ Counselling

OTHER HEALTH PROBLEM: