Date_____ Patient Questionnaire (please fill all fields)

Name_____Date of birth_____
Address_____Post code_____
Phone Hm_____Wk_____Mob_____
E Mail_____
Occupation_____Health Fund_____
Medical Doctor_____Location_____
How did you discover this service_____

Reason/s for consultation_____
What do you feel was the cause_____
How long have you had it_____Have this/these concern/s occurred before, how, when_____
Do you feel there are any other problems associated with your concern
Y / N_____
How do you rate your concern Mild 1 2 3 4 5 6 7 8 9 10 Severe
Is it constant or intermittent (circle)
What makes it feel better_____worse_____
Is it improving or deteriorating or remaining the same (circle)
How is this concern affecting your Life_____
Have you received any Tests/X-Rays/Scans/Treatment for this concern (circle)
Y/N What_____Where_____
What was the result_____
Do other members of your family have similar health problems_____
_____

With your current concern: (circle if appropriate)

Is there pain that radiates to another area. Where_____	Y / N
Is there pain with coughing, sneezing, or during a bowel movement	Y / N
Do you have difficulty urinating, or controlling your bowels	Y / N
Is there any pins and needles or numbness in your arms legs or face	Y / N
Have you had a recent fever or infection	Y / N
Do you have intense pain at night	Y / N
Have you recently lost a large amount of weight for no reason	Y / N
Have you had any blood in your urine or stool, black stool	Y / N
Do you have: High Blood Pressure, Blood Clots, or Bleeding Problems	Y / N
Do you suffer from: Dizziness, Blurred Vision, Nausea, Coordination problems	Y / N

Have you ever had / do have any serious:
Illness (including emotional/psychological), Injury, Surgery, Hospitalization etc.
Details_____
_____

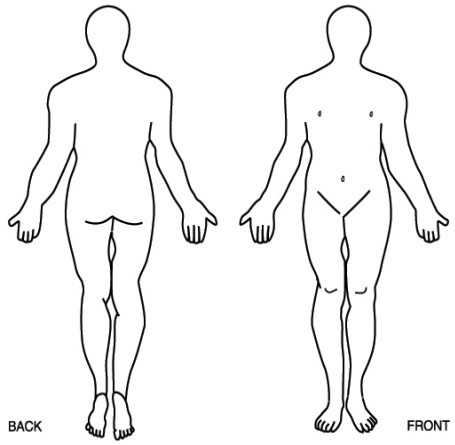
Please turn over to next page

Do you have any other health concerns_____

Medications/supplements/natural remedies etc and reason for use_____

_____

Please mark and label affected areas below



What does it feel like (circle):

Tight, Stiff, Painful, Catching, Sharp, Shooting, Dull, Aching, Throbbing, Pins and Needles, Crawling, Burning, Numb, Weak, Heavy.
Other_____

While all care and expertise is employed during treatment, not all variables and outcomes can be controlled or anticipated.

Spinal manipulation is one of the various methods used in this practice, according to the literature it carries a small risk of injury, including although not limited to; muscle and joint soreness, strains and sprains (to a ligament or disc, in the neck 1 in 139000, or low back 1 in 62000), fractures, strokes or stroke like symptoms from neck manipulation (1 in 5.85 million), or an exacerbation and/or aggravation of an underlying condition. Intervertebral disc injury may result in nerve pain in an arm or leg, changes in skin sensation, and muscle weakness. Severe cases of disc injury in the lower back may produce impaired bowel/bladder/genital function.

However to put things in perspective, one study shows that compared to receiving a course of anti-inflammatory drugs for spinal pain, Chiropractic is 250 times safer.

To our knowledge, no serious incident has ever occurred in this practice. The above information is simply derived from the available literature, and provided only for you to make an informed decision regarding your health care.

References: Magna report, Ontario Ministry of Health 1993, A risk assessment of cervical spine manipulation, JMPT 1994. Halderman, et al. Canadian Medical Asssociation Journal 2001:165 (7). Dabbs,V., & Lauretti,W.J. (1995). A Risk Assessment of Cervical Manipulation vs NSAIDs for the Treatment of Neck Pain. Journal of Manipulative and Physiological Therapeutics, 18(8), 530-536.

Soft tissue techniques may produce some temporary muscle soreness. Musculoskeletal Acupuncture may produce mild bleeding, temporary bruising, and discomfort. Electro-physical therapy may cause mild unpleasant sensations and some initial increase in symptoms. Various allergic or adverse reactions and drug interactions may possibly result from natural remedies. Somatopsychic techniques may produce greater emotional range and conscious awareness.

Due to the nature of the physical examination and treatment, various parts of the body may require physical contact. If at any stage you are uncomfortable with any of these procedures please inform the practitioner immediately.

For your benefit it may be required that the information in your file be provided to your other health care providers.

Patient declaration: The information I have provided here is correct to the best of my knowledge. I have read and I understand the above information. I consent to examination, treatment, and release of my records if required, with the following (If any) exceptions_____

Print Name_____Signed.....Date_____