• Chiropractic
• Massage

Catalyst Health and Wellness Group
604 Barkly Street, Ballarat, VIC 3350

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date: _____

Surname:	First Name:	Preferred Name:
Address:	Town:	
Medicare No:		Post Code:
Home Ph:	Work Ph:	Mobile Ph:
Birth Date: / /	Email:	
Occupation:	Employed by:	
Type of work: ☐ Sitting ☐ Computer ☐ Standing ☐ Driving ☐ Lifting ☐ Other_____		
Spouse's name:	Do you have a concession? ☐ Yes ☐ No ☐ Number:	
Children's name & ages:		
Method of payment for first visit: ☐ Cash ☐ Cheque ☐ Credit Card		
Do you have private health insurance that covers you for chiropractic care and / or remedial message therapy? Yes / No If yes, which fund _____		
Whom may we thank for referring you to our practice?		

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

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the main problem?_____
Is the pain ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Like pins & needles
Does the pain spread? ☐ Yes ☐ No If yes, to where?_____
Do you have numbness? ☐ Yes ☐ No If yes, where?_____
Is there pain when you cough or sneeze? ☐ Yes ☐ No If yes, where?_____
Is the pain when you sit or stand? ☐ Yes ☐ No If yes, where?_____
Is the pain getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes
Do you have headaches? ☐ Yes ☐ No If yes, circle all that apply:
Tension Throbbing Sinus Migraine Other:_____
Indicate any function below that aggravates or are aggravated by your condition *(please circle all that apply):*
Walking Steep climbing Driving Working Recreation Bowel movements Digestion
Vision Breathing Sinuses Hearing Smelling Sleeping If female, menstruation

Previous chiropractic care *(leave blank if no previous chiropractic care)*
Previous chiropractor's name:_____ Approximate date of last visit: _____
Type of care: Symptom based / Non symptom based *(wellness or maintenance)*
Duration of care: Days / Weeks / Months / Years
Techniques used: _____ / Not sure
Were you happy with care? Yes / No Why / why not? _____

Previous massage *(leave blank if no previous massage)*
Previous massage therapist's name:_____ Approximate date of last visit: _____
Type of care: Symptom based / Non symptom based *(wellness or maintenance)*
Duration of care: Days / Weeks / Months / Years
Techniques used: Relaxation / Deep tissue / Dry needling / Lymphatic / Remedial / Other _____
Were you happy with care? Yes / No Why / why not? _____

What do you think is wrong? _____
What do you think caused the problem? _____

Please list the health practitioners who were consulted for these conditions:

1. _____ Diagnosis given: _____
2. _____ Diagnosis given: _____
3. _____ Diagnosis given: _____

Imaging History			
☐ Previous x-rays	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous MRIs	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous CT scans	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Other imaging	Approx. Date: ___/___/___	Area:	Do you have a copy of report?

Please list any operations you have had:

1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had:

1. _____ 2. _____ 3. _____

Date of last physical: _____ / _____ / _____

General Practitioner's Details	
Name:	Clinic name:
Address:	

Is there any chance that you are pregnant? ☐ Yes ☐ No If Yes, how many weeks pregnant? _____ weeks

Date of onset of last menstrual period (if applicable): _____

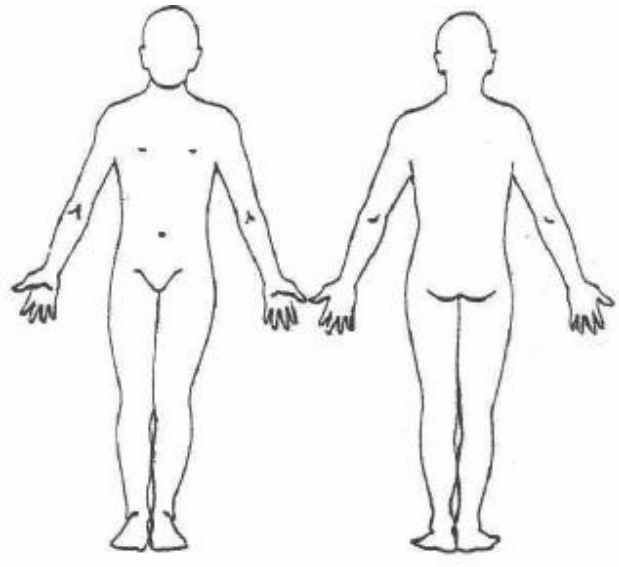
Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind? _____

Does you father, mother, sister, brother or children have similar problems? ☐ Yes ☐ No If yes, who? _____

Please mark areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
_____	OOOOOOOOO	XXXXXX	********	//////////////
_____	OOOOOOOOO	XXXXXX	********	//////////////

Pain Chart:



Neck/Shoulder/Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

When the pain is at its worst, how does it feel? _____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
☐ Moody	☐ Decision Making	☐ Lose patience with your family
☐ Irritable	☐ Poor attitude	☐ Restricted
☐ Interrupt sleep	☐ Decreased productivity	☐ Can't exercise or play sport
☐ Restrict your daily activities	☐ Exhausted at end of day	☐ Interference with hobbies/activities

Health Questionnaire

Please tick the appropriate box if you have had any of the following symptoms in the past **6 months.** Leave blank any that do not apply.

(O = Occasionally, F = Frequently, C = Constantly)									
	O	**F**	**C**	**Head**		**O**	**F**	**C**	**Genito-Urinary System**
1.	☐	☐	☐	Headaches	42.	☐	☐	☐	Frequent Urination
2.	☐	☐	☐	Light Headaches	43.	☐	☐	☐	Painful Urination
3.	☐	☐	☐	Loss of Balance	44.	☐	☐	☐	Difficulty Starting Urine
4.	☐	☐	☐	Hearing Loss	45.	☐	☐	☐	Dribbling Urine
5.	☐	☐	☐	Ringing in Ears	46.	☐	☐	☐	Difficulty Controlling Urine
6.	☐	☐	☐	Buzzing in Ears	47.	☐	☐	☐	Bed Wetting
				Neck	48.	☐	☐	☐	Kidney Infection
7.	☐	☐	☐	Pain	49.	☐	☐	☐	Bladder Infection
8.	☐	☐	☐	Ache	50.	☐	☐	☐	Prostate Trouble
9.	☐	☐	☐	Soreness / Stiffness					**Females Only**
10.	☐	☐	☐	Grating Sensation	51.	☐	☐	☐	Painful or Tender Breasts
				Shoulder, Arm or Fingers	52.	☐	☐	☐	Lumps in Breasts
11.	☐	☐	☐	Pain	53.	☐	☐	☐	Period Pains
12.	☐	☐	☐	Pins / Needles Sensation	54.	☐	☐	☐	Excessive Menstrual Flow
13.	☐	☐	☐	Numbness Sensation	55.	☐	☐	☐	Scanty Menstrual Flow
14.	☐	☐	☐	Restricted Movement	56.	☐	☐	☐	Irregular Periods
15.	☐	☐	☐	Swollen Joints	57.	☐	☐	☐	Bleeding Between Periods
16.	☐	☐	☐	Loss of Strength	58.	☐	☐	☐	Hot Flushes
				Chest	59.	☐	☐	☐	Menopausal Symptoms
17.	☐	☐	☐	Pain in Chest	60.	☐	☐	☐	Vaginal Discharge
18.	☐	☐	☐	Pain around Ribs	61.	☐	☐	☐	Painful Intercourse
19.	☐	☐	☐	Shortness of Breath	62.	☐	☐	☐	Number of Children you Have
20.	☐	☐	☐	Wheezing	63.	☐	☐	☐	No. of miscarriages if any
21.	☐	☐	☐	Tightness around Chest					**General Symptoms**
22.	☐	☐	☐	Rapid Heart Beat	64.	☐	☐	☐	Allergies
23.	☐	☐	☐	Thumping Heart	65.	☐	☐	☐	Sinus Trouble
				Stomach or Abdomen	66.	☐	☐	☐	Chills
24.	☐	☐	☐	Nervous Stomach	67.	☐	☐	☐	Convulsions
25.	☐	☐	☐	Belching or Excessive Wind	68.	☐	☐	☐	Dizziness
26.	☐	☐	☐	Nausea	69.	☐	☐	☐	Asthma
27.	☐	☐	☐	Pain in Stomach	70.	☐	☐	☐	Fainting Sensation
28.	☐	☐	☐	Gall Bladder Trouble	71.	☐	☐	☐	Excessive Fatigue
29.	☐	☐	☐	Liver Problems	72.	☐	☐	☐	Fevers
30.	☐	☐	☐	Constipation	73.	☐	☐	☐	Sudden Loss of Weight
31.	☐	☐	☐	Diarrhoea	74.	☐	☐	☐	Loss of Sleep
32.	☐	☐	☐	Colitis	75.	☐	☐	☐	Nervousness
33.	☐	☐	☐	Excessive Hunger	76.	☐	☐	☐	Depression
34.	☐	☐	☐	Hernia	77.	☐	☐	☐	Sweating Excessively
35.	☐	☐	☐	Groin pain	78.	☐	☐	☐	Tremors
				Low Back, Legs or Feet	79.	☐	☐	☐	Poor Circulation
36.	☐	☐	☐	Pain	80.	☐	☐	☐	High Blood Pressure
37.	☐	☐	☐	Pins / Needles Sensation	81.	☐	☐	☐	Low Blood Pressure
38.	☐	☐	☐	Numbness Sensation					
39.	☐	☐	☐	Restricted Movement					
40.	☐	☐	☐	Swollen Joints					
41.	☐	☐	☐	Varicose Veins					

Physical Stress

Have you experienced any physical traumas, such as car accidents, sporting accidents, falls etc *(Please include seemingly insignificant traumas)* at any stage of your life – even as a child?

☐ Yes ☐ No _____

_____

_____

_____

If female, briefly explain all childbirth experiences (duration of labour, birthing position, medications, complications, interventions etc).

_____

_____

_____

_____

Is your work physically demanding? ☐ Yes ☐ No

Explain _____

_____

Is there anything that you know that you do that affects your posture?

Explain _____

_____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

What exercise do you currently do and how often do you do it? _____

_____

_____

Sleep

Do you struggle to fall asleep?	☐ Yes	☐ No
Do you wake up feeling tired?	☐ Yes	☐ No
Do you wake up with pain or stiffness in your back?	☐ Yes	☐ No
Do you sleep less than 7-8 hours?	☐ Yes	☐ No
Do you ever sleep on your stomach?	☐ Yes	☐ No
Do you fall asleep on your couch?	☐ Yes	☐ No
Is your bed more than 7 years old?	☐ Yes	☐ No
Is your pillow more than 2 years old?	☐ Yes	☐ No
Do you travel often?	☐ Yes	☐ No
Are you a shift worker?	☐ Yes	☐ No
Are you pregnant or considering having children?	☐ Yes	☐ No

Feet

Do you think that you have problems with your feet?	☐ Yes	☐ No
Explain: _____		
_____		
Have you ever visited a podiatrist for mechanical foot problems?	☐ Yes	☐ No
If so explain _____		
_____		
Do you wear Orthotics?	☐ Yes	☐ No
If you wear orthotics, are they over 3 years old?	☐ Yes	☐ No

Podiatrist's Details	
Name:	Clinic name:
Address:	Approximate date of last visit:

Please tick the box if you experience…

☐ Ball of foot or toe pain
☐ Arch pain
☐ Heel pain
☐ Lower leg pain
☐ Knee pain
☐ Hip pain
☐ Low back pain
☐ Postural imbalance

Are your feet tired or sore at the end of the day? ☐ Yes ☐ No
Do you spend a lot of time on your feet each day? ☐ Yes ☐ No

Teeth

Dentist's Details	
Name:	Clinic name:
Address:	Date of last visit:

Orthodontist's Details	
Name:	Clinic name:
Address:	Date of last visit:

Have you ever had teeth removed? ☐ Yes ☐ No
Have you ever had braces? ☐ Yes ☐ No
Do you have sleep apnoea? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Are you / were you a bed wetter? ☐ Yes ☐ No

Chemical Stress

How could your diet improve? _____
_____

Do you drink alcohol? ☐ Yes ☐ No
If so how much? _____
_____

Do you drink caffeinated drinks? ☐ Yes ☐ No
If so how many and what type? _____
_____

How many litres of water do you drink per day?
☐ One litre ☐ Two litres ☐ Three litres ☐ Four litres

Are you aware of any food allergies or foods that disagree with you? ☐ Yes ☐ No
If so what are they? _____
_____

Do you ever choose to eat organic food? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
If so, how many cigarettes per day? _____

Current Medications / Supplements / Probiotics		
Medication Name	**Reason for taking**	**Dosage**
Supplement Name	**Reason for taking**	**Dosage**
Probiotic Name	**Reason for taking**	**Dosage**

Emotional Stress

Please mark the line with an 'x'

Is your work stress
LOW _____ HIGH

Is your relationship stress
LOW _____ HIGH

Is your family stress
LOW _____ HIGH

Is your financial stress
LOW _____ HIGH

Do you consider yourself an **emotional, stressful, anxious or depressed** person? *Please circle*

Have there been moments in your life where you have felt an inability to cope? ☐ Yes ☐ No

Your Health Goals

The purpose of this section is to enable your practitioner to know what YOUR health objective are, what YOUR expectations are and what is important to YOU. **(Please circle your answer).**

Are you happy with the way you look and feel?	☐ Yes	☐ No	
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

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What are you most interested in improving?

- ☐ Overall Health
- ☐ Less Pain / Symptoms
- ☐ Reducing Stress
- ☐ Increasing your Energy and Vitality
- ☐ Other, Explain _____

How long do you think it will take to achieve your health goals? ☐ Years ☐ Months ☐ Days

Please list you desired health goals and the areas you are most interested in improving:

_____

_____

PATIENT SIGNATURE: _____ Date: / /

PRACTITIONER 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, including assessment and treatment, which you should be informed about.

Please read the following carefully:

1. I acknowledge that I have discussed with my Chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments / ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Suck risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I also acknowledge the following additional potential risks in so far as my proposed care is concerned have been explained to me.
   ……
   ……
   ……
   ……
   ……
   ……
   ……
   ……

3. I have had the opportunity to discuss the proposed care with my chiropractor. 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 care to proceed.

4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by the chriropractor stated below and/or any other chiropractor working in this clinic. I understand I can withdraw consent at any time.

7. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** eg between 1 in 2 million to 1 in 5.85 million – Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (**Current statistics** eg less than 1 in 139,000) and low back (**Current statistics** 1 in 62,000 Dvorak study in Principals and Practice of Chiropractic Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.*

……..…….……..	……..…….……..
Patient's Signature *(Parent or Guardian to also sign if patient is under 18)*	Chiropractor's Signature
……..…….……..	……..…….……..
Patient's Name *(Printed)*	Chiropractor's Name *(Printed)*
……..…….……..	……..…….……..
Date	Date