CATALYST CHIROPRACTIC

Catalyst Health and Wellness Group
602 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:		
Do you have private health insurance that covers you for chiropractic care? Yes / No If yes, which fund: _____		
Referred By: ✈ Family or Friend – Name: _____ ✈ Signage ✈ Google ✈ Facebook		

Please <u>list</u> your chief complaints in order of severity;
Or <u>tick here</u> 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 there 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 is 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

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

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? _____

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?

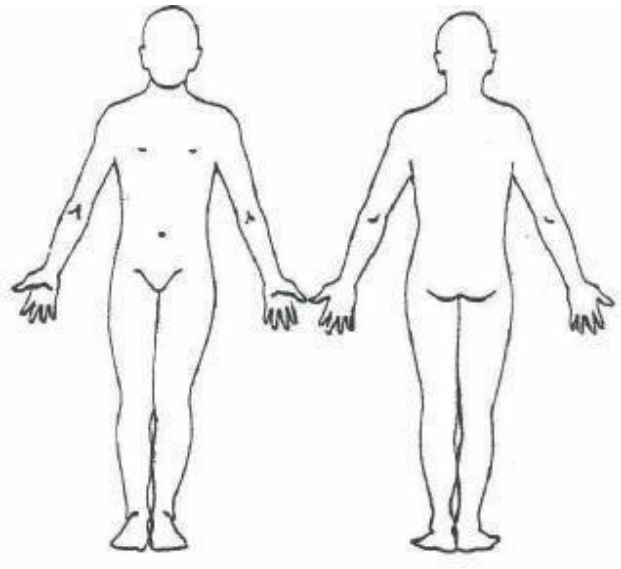
Please list any operations you have had:
1. _____ 2. _____ 3. _____
Please list any serious illnesses you have had:
1. _____ 2. _____ 3. _____

General Practitioner's Details	
Name:	Clinic name:

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

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	********	//////////////



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

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

List any ALLERGIES: _____

List any MEDICATIONS (include prescription, non-script) or Supplements that you take: _____

_____

Please indicate if you have **EVER** had, currently or in the past, any problems in the following areas:

Current/Past	Current/Past	Current/Past
☐☐ Eyes/Vision (Blurring etc)	☐☐ Bladder control / Infections	☐☐ Growing Pains
☐☐ See spots / lights / halos	☐☐ Bowels	☐☐ Balance / Coordination
☐☐ Ears / Hearing / Ringing in ears	☐☐ Constipation / Diarrhoea	☐☐Attention / Concentration
☐☐ Nose / Jaw / Throat	☐☐ Blood Pressure High / Low	☐☐ Speech / Taste
☐☐ Neck	☐☐ Reproductive organs	☐☐ Nausea / Vomiting
☐☐ Shoulders / Upper Arm	☐☐ Nervous System	☐☐ Forgetfulness
☐☐ Elbows / Forearms	☐☐ Headaches / Migraines	☐☐ Mood Changes
☐☐ Wrists / Hands	☐☐ Allergies / Hay Fever	☐☐ Fatigue / Exhaustion
☐☐ Upper Back	☐☐ Dizziness	☐☐ Anxiety / Depression
☐☐ Lower Back	☐☐ Diabetes / Pancreas	☐☐ Cramps
☐☐ Pelvis / Hips / Coccyx	☐☐ Thyroid	☐☐ Jumpy legs at night
☐☐ Groin / Thighs	☐☐ Indigestion / Reflux	☐☐ Motion Sickness
☐☐ Calves / Lower Legs	☐☐ Hearth / Circulation	☐☐ Unexplained bleeding
☐☐ Knees / Ankles / Feet	☐☐ Kidneys	☐☐ Loss of appetite
☐☐ Chest / Lungs / Asthma	☐☐ Inflammatory Arthritis	☐☐ Weight loss / gain
☐☐ Low Energy	☐☐ Knocked Unconscious	☐☐ Fainting / Blackouts

Legs and Feet

1. Do you experience pain in your legs or feet? ☐ Yes ☐ No
2. Do you think you have mechanical foot problems? ☐ Yes ☐ No
3. Are you interested in general foot care? ☐ Yes ☐ No

FAMILY HISTORY - Have any of your family members suffered from:

Heart Disease **Yes / No, who?** _____
Cancer **Yes / No, who?** _____
Stroke **Yes / No, who?** _____
Inflammatory Arthritis **Yes / No, who?** _____

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 encroachments/ruptures, causing nerve irritation and referred symptoms, strong (or like episodes), and an exacerbation and/or aggravation of my underlying condition. Such 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 under the potential risks. I appreciate that results are not guaranteed.
5. I do no except 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 chiropractor state below and/or any other chiropractor working at Catalyst Health and Wellness Group. I understand I can withdraw my consent at any time.
7. In very rare circumstances, some treatments of the neck my 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 Halderman 2nd Ed*). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

Patient Signature: …… **Chiropractor's Signature:** ……..…….

Patient Name: …… **Chiropractor's Name:** ……
(Parent or Guardian to sign if patient is under 18)

Date: **Date:**