



Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

LAST NAME

\_\_\_\_\_  
 FIRST NAME MIDDLE NAME

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Partner's Name \_\_\_\_\_  Separated  Divorced  Partnered  Single  Minor < 18

Employer/ School \_\_\_\_\_

Occupation \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Contact Number \_\_\_\_\_

**Who may we thank for referring you?**

\_\_\_\_\_

**HOW CAN WE HELP YOU?**

What brings you in today? \_\_\_\_\_

If you are already experiencing a symptom, what is it? \_\_\_\_\_

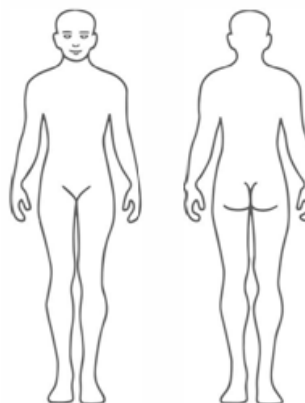
How bad is it? How intense are your symptoms? (circle)



Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramping
- Nagging
- Sharp
- Shooting
- Burning
- Throbbing
- Stabbing
- Swelling
- Other \_\_\_\_\_



**IMPACT OF YOUR SYMPTOMS**

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?



## PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONG TERM \_\_\_\_\_

## CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_

Children's health concerns? \_\_\_\_\_

Children's names & ages \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

## HEALTH & ILLNESS HISTORY

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues         | <input type="checkbox"/> Headaches   Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness          | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues           | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> TMJ Issues      |
| <input type="checkbox"/> Asthma/Allergies      | (Constipation/Diarrhea/GERD/IBS)                    | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> Urinary Issues  |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Elbow/Wrist/Hand Issues    | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Foot/Ankle Issues          | <input type="checkbox"/> Neck Pain             |  |
|  | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Reproductive Issues   |  |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENTS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## HISTORY OF TRAUMA

Motor Vehicle Accidents?:: \_\_\_\_\_

Work Activities:: \_\_\_\_\_

Sports Activities:: \_\_\_\_\_

Fractures/Scars: \_\_\_\_\_

Misc.: \_\_\_\_\_

## CHIEF COMPLAINT

When Did It Start? \_\_\_\_\_ Constant \_\_\_\_\_ Intermitant \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_

What Makes It worse:: \_\_\_\_\_

What Makes it Better:: \_\_\_\_\_

What is the pain like?:    Sharp    Burning    Tight    Other \_\_\_\_\_

Any Time Patterns? How Long Does It Last?: \_\_\_\_\_

Anything Else Associated With The Pain?: \_\_\_\_\_

Does it Radiate? Move Anywhere Else?: \_\_\_\_\_

Any Associations e.g. sweating, vomiting \_\_\_\_\_

## NOTES ON LIFE EFFECT

Work \_\_\_\_\_     Sleep \_\_\_\_\_     Patience \_\_\_\_\_

Exercise \_\_\_\_\_     Self-Care \_\_\_\_\_     Productivity \_\_\_\_\_

Recreation \_\_\_\_\_     Energy \_\_\_\_\_     Creativity \_\_\_\_\_

Relationships \_\_\_\_\_     Attitude \_\_\_\_\_     Other \_\_\_\_\_

Please list the operations you have had:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Are you a smoker?    Yes    No    If 'yes', How many cigarettes per day? \_\_\_\_\_

If we could help you improve areas of your life, which would they be?

Energy Levels

Quality of Sleep

Concentration

Breathing

Digestion

Sexual Function

Stress levels

Flexibility

Hormone Balance

Co-ordination/Balance

Muscle Strength

Weight Control

Exercise Recovery

Immune System

Bladder Function



IF YOU HAVE HAD CHIROPRACTIC CARE BEFORE, PLEASE COMPLETE THE FOLLOWING:  Y  N

Name of Chiropractor: \_\_\_\_\_

Location: \_\_\_\_\_

When was your last adjustment? \_\_\_\_\_

When did the Chiropractor last take X-Rays? \_\_\_\_\_

## PATIENT INFORMATION - INFORMED CONSENT

Chiropractic is one of the most widely used drug free health care professions in the world. For your own awareness we have chosen to inform you of very unlikely but possible risks associated with chiropractic.

- Very rare risks may include post adjustment muscle soreness, strain to a ligament or disc in the neck/lower back, and possible aggravation of underlying conditions.
- Extremely rare is the risk of damage to neck blood vessels which can arise in a stroke or stroke- like symptoms.

Chiropractic adjustments of the spine are internationally recognised as being far safer statistically than medication and other alternatives. If you have any questions relating to the care you are about to receive, please speak to your chiropractor.

I acknowledge the above information and do not expect the chiropractor to be able to anticipate all potential risks and complications. Based on the information provided, I consent to and look forward to receiving chiropractic care in this office, if required.

\_\_\_\_\_  
*Patients Name - Please Print*

\_\_\_\_\_  
*Patient's Signature*

*Dr Peter Hobson*  
*Dr Yaron Robinstein*

\_\_\_\_\_  
*Chiropractors Signature*

Date: \_\_\_\_\_

### **Risk Ratios & Statistics: Cervical Spine**

#### **(Neck)**

-(Temporary) Radiculopathy associated with disc injury 1:139,000  
-Vascular injury 1:5.85 million

#### **Lumbar Spine**

-Disc injury with radiating pain 1:62,000  
-Radiculopathy 1:188,000  
-Cauda Equina syndrome 1:565,000

#### **In comparison**

-Hospitalisation for gastro intestinal bleeding (NSAID) 1:250  
(following 1 month of medication)  
-Deaths associated with NSAIDS (US) 3200pa (AUST) 360 pa  
-Deaths from general anaesthetic 1:1250  
-Injury from motor vehicle accidents 1:9300  
-Hospitalisation from adverse drug reactions 20,000 - 26,000 pa

