HINTERLAND CHIROPRACTIC CENTRE
7 Price St, Nerang, 4211
Ph 07 5527 3133

CONFIDENTIAL PATIENT INFORMATION

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

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 _____

Employer/ School _____

Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you?

_____

☐ Partner's Name _____ ☐ Separated ☐ Divorced ☐ Partnered ☐ Single ☐ Minor < 18

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

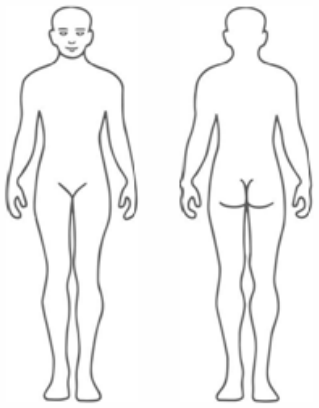
If you are already experiencing a symptom, what is it? _____

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

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

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
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

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? _____

Childrens' health concerns? _____

Childrens' names & ages _____

_____

_____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

❑ $0 ❑ $25 ❑ $45 ❑ $75 ❑ $285 ❑ $ _____ ❑ Reactivation ($45) Last Visit: _____

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
☐ Breathng	☐ 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) (following 1 month of medication)	1:250
-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