Welcome to

SUBIACO CHIROPRACTIC

Surname (please print) | Given Name

Address / Postcode

DOB | Age | Health Fund | Pensioner Y N

Occupation | Veteran Affairs Y N | Senior Y N

Hobbies | Phone | Mobile

GP Name and Address | Email *(Please tick primary contact)*

Work compensation related injury? Y N

Who/ What recommended you to visit us?

Have you tried Chiropractic before? Y N | Did it help? Y N | Previous X-rays? Y N

Do you require a reminder for appointments? Y N

Do you want quick fix or long term changes?

Any areas you **do not** want treated or examined? Neck | Mid Back | Lower Back | Other

What would you like addressed through treatment at our clinic?

How long have you had symptoms? | Rate pain/disability out of 10: | Have you had these symptoms before? Y N | When was the first episode?

How did it occur? Gradual | Trauma | Sudden | Unknown | Details

Type of pain? Sharp | Dull | Constant | Intermittent | Throbbing | Ache | Other

What aggravates the condition? | What relieves?

Please consider the following & tick relevant factors.

Lower Back | Pain/tension Location: Central | Left | Right | Both | Other:

Associated Concerns: Buttock | Hip | Thigh | Knee | Calf | Ankle | Foot | Toes | Abdominal Pain | Ovary | Testicle | Haemorroids | Menstral problems

Mid Back/Chest | Pain/tension Location: Central | Left | Right | Both | Front | Back | Other

Associated Concerns: Shoulder : Arm | Elbow | Wrist | Hand | Chest Pain | Breathing Difficulties | Indigestion | Reflux | Heart Palpitations

Neck/Shoulder | Pain/tension Location: Central | Left | Right | Both | Other:

Associated Concerns: Headache | Migraine | Vision | Dizziness | Sensation | Face | Scalp | Jaw | Sinus

Pins & Needles Numbness Weakness: Face | Scalp | Tongue | Swallowing | Arms | Hands | Legs | Feet

Bowel & Bladder | Recent Changes: Constipation | Diarrhoea | Controlling Problems | Bed Wetting | Sensation Changes

Night Symptoms: Pain Wakes | Movement Pain | Sweating | Sleeping probs

Other Symptoms: Inflammation | Rash | Variscose Veins | Allergies | Persistant cold/cough | Restless Legs | Feel off balance | Fatigue | Cramps | Joint Swelling

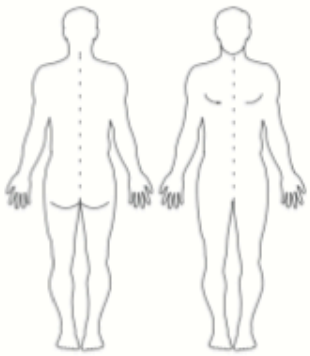
Unexplained weight loss? Y N | Pregnant? Y N | Fertility Problems? Y N

Medical history of illnesses, conditions, family history, stroke, cancer, diabetes, heart disease, high or low BP, osteoporosis, arthritis, depression.

Current medication required for? | Any hospitalisations / surgeries?

Any injuries, falls, accidents, motor vehicle, whip lash, fractures, dislocations?

Distribution



Referral

Radiculopathy

Posture

Slump / Erect	Cervical Rot 80/80 F/E 60/75
Hard Kyphosis:	Thoracic
Stress Areas:	Lumbar LF 20/20 ROT 30/30 F/Adams 45/90
Core Activation:	Antagic
Walking /Squat	

Ht:	Wt:	L:	R:	Handed L R	Footed L R	Swing L R

DISC	FACET	POSTURAL	MUSCLE	LIGAMENT	TENDON	VISCERAL

Complicating factors

- Previous Injury
- Previous Surgery
- Degeneration
- Systemic Illness
- Long Standing Hx
- Significant Trauma
- Scoliosis

Positive Tests:	VAT	Heel/Toe	LL	SLR L	R
Sensory				PF L	R
Motor				PT L	R
Reflex				ST L	R

Date	Notes	Legs, L5, CT

Posture chnage with first visit:

- Face
- Neck
- Chest
- Shoulders
- Core
- Pelvis
- Knees

SUBIACO CHIROPRACTIC

Your history

Given Name and Surname (please print)

Date

During the course of your life's journey you may have encountered many stressors. Whilst some of these stressors may have seemed small, they may have had an accumulating effect on your life. Please answer the questions on the following issues that commonly arise through the formative years.

Lifestyle

Do you have any problems with bed rest, sitting or standing?	Y Yes	N No	U Unsure
Do you drink alcohol?	Y Yes	N No	U Unsure
Do you smoke?	Y Yes	N No	U Unsure
Do you drink adequate water?	Y Yes	N No	U Unsure
Do you eat healthy foods?	Y Yes	N No	U Unsure
Are your teeth healthy?	Y Yes	N No	U Unsure
Do you sleep well?	Y Yes	N No	U Unsure
Do you exercise regularly?	Y Yes	N No	U Unsure
Are your physically stressed?	Y Yes	N No	U Unsure
Are you mentally stressed?	Y Yes	N No	U Unsure
Are you being, or have been exposed to chemicals?	Y Yes	N No	U Unsure
Are you taking, or have ever taken drugs?	Y Yes	N No	U Unsure

Health Objectives

Please indicate which ones apply to you.

Y Relief of my symptoms Y Correction of my underlying problems Y To maximise my health

How would you rate your overall health?	1 2 3 4 5 6 7 8 9 10
What rating would you like your health to be?	1 2 3 4 5 6 7 8 9 10

Mental/Emotional

Was there a loss of a close relative	Y Yes	N No	U Unsure
Was there any stress in the family?	Y Yes	N No	U Unsure
If yes to any of the above, please provide details			

Birth process

Was your birth early / late (according to the due date)	Y Yes	N No	U Unsure
Induced Labor?	Y Yes	N No	U Unsure
Was delivery long?	Y Yes	N No	U Unsure
Was the delivery difficult?	Y Yes	N No	U Unsure
Caesarean (Elective/Emergency)?	Y Yes	N No	U Unsure
Presentation position: Posterior, Breech, Correct, Transverse, other			

Physical

Physical abuse by siblings / others?	Y Yes	N No	U Unsure
Violently pulled by the arm?	Y Yes	N No	U Unsure
Were you a head banger?	Y Yes	N No	U Unsure
Did you fall on your head?	Y Yes	N No	U Unsure
Did you fall down any stairs?	Y Yes	N No	U Unsure
Did you ever have the chair pulled out from underneath you?	Y Yes	N No	U Unsure
Were you taught how to care for your spine?	Y Yes	N No	U Unsure

Chemical

Do you work with toxic chemicals?	Y Yes	N No	U Unsure

Thank you for completing this form.

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