98248 Dive Chiropractic Centre Case History FRONT Black

Patients In-Depth Symptoms Survey

Please answer the following questions about your general health. This information may seem unimportant and not related to your chief complaint ***but*** it will give us a more complete understanding about your body's overall function so we can better evaluate the problem.

Please tick (✓) any of the following symptoms/conditions under the appropriate heading as they may apply to you.

OCCASIONALLY	FREQUENTLY	CONSTANTLY		OCCASIONALLY	FREQUENTLY	CONSTANTLY	
____	____	____	Headache	____	____	____	Neck Pains/Stiffness
____	____	____	Dizziness	____	____	____	Shoulder Problems
____	____	____	Visual Disturbances	____	____	____	Numbness/Tinging Sensation
____	____	____	Depression	____	____	____	Upper Back Problems
____	____	____	Nervousness	____	____	____	Stomach Problems
____	____	____	Loss of Energy	____	____	____	Bladder Problems
____	____	____	Ringing/Buzzing Ears	____	____	____	Female Problems
____	____	____	Faintness/Lightheaded	____	____	____	Liver Problems
____	____	____	Sleeping Problems	____	____	____	Kidney Problems
____	____	____	Poor Circulation	____	____	____	Colon Problems
____	____	____	High Blood Pressure	____	____	____	Lower Back Problems
____	____	____	Low Blood Pressure	____	____	____	Hip Problems
____	____	____	Chest Pains	____	____	____	Leg Pains/Cramps
____	____	____	Heart Palpitations	____	____	____	Constipation/Diarrhoea

Please mark your areas of pain on the figures below.

Doctor notes: ____________________

CHIROPRACTIC HEALTH CENTRE

IMPORTANT - PLEASE READ CAREFULLY

Welcome to our Clinic,

You should know that our purpose in this Clinic is to relieve pain, restore health and prolong life in each patient we accept for treatment. To do this properly we must not only find the true, basic, underlying cause of the health problem but we must also determine exactly what needs to be done to correct the problem. This is our responsibilty to our patients regardless of whether the symptoms for which they are consulting us are seemingly very simple or highly complicated.

For us to properly understand your condition, we require a complete description of not only your present symptoms but also your overall health pattern, both past and present. This valuable information will help us to better evaluate your problem and it will help determine what type of response to our treatment we can expect from your body.

In order to save us both a lot of talking time during consultation we ask that you complete this “Confidential Case History Form”. Please be as neat and as accurate as possible and be sure to fill in all sections completely.

Please Note: Your health and our reputation for getting results are at stake on every patient we accept for treatment and we refuse to gamble with either one. If after either consultation and/or examination we do not definitely feel you will benefit from our services, we will not accept you as a patient in this Clinic.

Thank you.

To Book your Appointment please Call..

Mermaid Beach	Labrador	Kallangur
07 5527-7500	07 5571-1303	07 3285-5977

98248 Dive Chiropractic Centre Case History INSIDE Black

Confidential Patient Case History

Date ______ Name ______ Phone ______ (H) ______ (W)

Address ______ City ______ State ______ P/C ______

Email Address ______

DOB ______ Age ______ ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ Male ☐ Female Are you pregnant? ☐ Yes ☐ No Date of last period ______ No. of Children ______

Occupation ______ Employer ______

Spouses Occupation ______ Employer ______

Who or What referred you to this Clinic? ______

Are you a member of a Health Fund? ☐ Yes ☐ No

Does it cover Chiropractic Care? ☐ Yes ☐ No ☐ don't know

What is the name of your Fund? ______

If you have Chiropractic Care before please complete the following

Name of Chiropractor ______ Location ______

What were you being treated for at the time? ______

How many treatments were given? ______ How frequent? ______

When was your last treatment? ______

What were the results of your treatment/s? ☐ Excellent ☐ Fair ☐ No Help ☐ Good ☐ Poor ☐ Got Worse

Did the Chiropractor take x-rays? ☐ Yes ☐ No Did he/she examine you thoroughly? ☐ Yes ☐ No

Previous Health History

Have you ever:

Had a serious illness or health problem? ☐ No ☐ Yes ☐ In the past 3 years ☐ Over 3 years

If yes, describe what ______

Had any operations? ☐ No ☐ Yes ☐ In the past 3 years ☐ Over 3 years

If yes, describe what ______

Been examined or treated by a MD or Specialist in past 3 years? ☐ No ☐ Yes

If yes, describe what for ______

Had any broken bones? ☐ No ☐ Yes ☐ In past 3 years ☐ Over 3 years

If yes, describe what ______

When was your last	Less than 6mths	6-18mths	Over 18mths	Never
Spinal Examination	______	______	______	______
Physical Examination	______	______	______	______
Blood Test	______	______	______	______
Chest X-Ray	______	______	______	______
Spinal X-Ray	______	______	______	______
Urine Test	______	______	______	______

Chief Complaint Record

What is the major symptom or complaint for which you are consulting us now? (Please describe)

______

______

______

______

Have you ever had these or similar symptoms before? ☐ Yes ☐ No

If yes, when ______ What caused them then? ______

When did your present symptoms begin this time? ______

What caused your present symptoms?

☐ Fall ☐ Mental Stress ☐ Auto Accident ☐ Unknown

☐ Strain ☐ Illness ☐ On-the-job Injury

What were you doing when these symptoms started? ______

Have the symptoms been:

☐ Getting progressively worse ☐ Staying about the same

☐ Getting better ☐ Seem to come and go

What makes your symptoms better? ______

What seems to make your symptoms worse? ______

Have you consulted anyone about your present symptoms? ☐ No ☐ Yes - when? ______

If yes, was it a ☐ MD ☐ Specialist ☐ Chiropractor ☐ Physiotherapist ☐ Other

What was their diagnosis? ______

What treatment was given? ______

What was the result of the treatment? ______

Have you been in a Bike Accident? ☐ No ☐ Yes Car Accident? ☐ No ☐ Yes

☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Have you been taking drugs or medication? ☐ No ☐ Yes

☐ If yes, what? ☐ Nerve Pills ☐ Relaxants ☐ "Pep" Pills

☐ Pain Killers ☐ Depressants ☐ Birth Control Pills ☐ Other

What is the age of your mattress? ______ Is your bed comfortable? ☐ No ☐ Yes

Do you use a bed board? ☐ No ☐ Yes

Do you sleep on your stomach? ☐ No ☐ Yes

How many pillows do you use? ______

How long has it been since you really felt well? ______

Note: Any and all information, written or otherwise, that you give us is confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any other doctor without the written permission of the patient.

Date ______ Patient's Signature ______