

CONFIDENTIAL PATIENT INFORMATION

Welcome to Barham Chiropractic ... our mission is to positively change the health and wellbeing of the world, one person at a time. To enable us to best assist you with positively changing your health and to achieve your lifestyle goals, please complete the following questionnaire.

Personal Information

Full name:		Date:	
Address:			
Street	City	State	postcode
Home phone: ()		Work phone: ()	
Mobile phone:		Email address:	
Marital status: M S W D	Spouse/guardian name:		
Date of birth:	No. of children:		
Occupation:	Spouse's Occupation:		
Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Health Fund Company			
Does it cover Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of person responsible for your fees:			

Who may we thank for referring you?

What is the major Health Concerns that Brought You Into This Office?

Health Concerns

Please list your health concerns according to their severity (eg Low Back Pain)	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Describe your pain eg dull, sharp, radiates etc?

Is the problem: Getting worse? Getting better? About the same?

What have you done for this condition? Was it of benefit? _____

I do (do not) have a family history of this or similar symptoms (Please explain):

What activities aggravate your condition?

Other practitioners you have seen for this condition:

Other Chiropractor	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Medical doctors Name:	Date of Last visit
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Have you had to make changes in your life due to this pain, illness, condition, etc? Y / N
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History

The accumulation of stresses on our body over time establishes our level of health and this influences the severity of our symptoms and our ability to heal. Please pay close attention to this as it will help us to help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	
2. Type:	When?	
3. Type:	When?	
4. Type:	When?	

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs or nutritional supplements you have taken in the past 6 months and why: (prescription and non-prescription) and why.

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
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If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Do you suffer from food allergies or is there a particular type of diet that you usually follow?

Past Health History

Please mark the following conditions you may previously had or currently have .. (P - previous, C - current):

<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Hand Pains	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Low back pain/ stiffness	<input type="checkbox"/> Hip Joint stiffness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Finger Numbness	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney pain	<input type="checkbox"/> Buttock Pain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Heartburn/ indigestion	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Depression
<input type="checkbox"/> Migraines	<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation	<input type="checkbox"/> Menstrual Difficulties	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Ear Disorders	<input type="checkbox"/> Shoulder Pain/ Stiffness	<input type="checkbox"/> Mid-back Pain	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hernias	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Leg Numbness

Stressors

Because accumulation of stress affects our health and ability to heal and may be the cause of our health condition, please list any obvious stresses (you have ever had) in each category:

- Physical stress (falls, accidents, work postures, etc.)

- Bio-chemical stress (cigarettes, unhealthy foods, missed meals, don't drink enough water, drugs/ alcohol, etc.)

- Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help to better understand you which has not been discussed?

Important Information About This Practice And Your Privacy

From 21 December 2001, new privacy laws came into effect in Australia that regulate the way the Practice handles your personal information. These laws give you new rights, such as the right to access personal information held about you and the right to correct it if needed. The new laws also state how the Practice may collect, disclose, store and keep safe your personal information.

To enable the Practice to continue to deliver and enhance the products and services it provides, the Practice holds personal information about you. We recognize and support your right to privacy in relation to this information and will continue to handle it with care and in accordance with our professional and legal requirements.

The Practice staff will continue to demonstrate integrity and understanding by keeping secure your personal information.

We ask you to read the Practice's "**Privacy Statement**". We invite you to contact our Privacy Officer if you would like to discuss this matter further.

If you wish to know more about our information handling practices you may ask us about our "**Privacy Policy**".

I understand that this clinic does not hold accounts and that all fees are payable at the time of service and cannot be deferred to a later date.

I have read the section regarding my personal information and understand this Practice's position on patient privacy.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

Print Patient Name: _____ Date: _____

Signature: _____

(Or Parent/ Guardian signature if under 18)

Name of Parent/ guardian: _____