Initial Treatment Application

Please Print Clearly in block letters!

Personal Information

Name _____ DOB _____

Address _____

Suburb _____ Postcode _____

Ph(H) _____ Ph(M) _____ Ph(W) _____

Email _____

Occupation _____

Marital status _____

Children (number) _____ Ages _____

Marketing Information - Please fill in as much or as little as you wish in this section

How did you hear about us?

☐ Friend (We'd like to thank them!) _____

☐ Professional Referral _____

☐ Newspaper (Which?) _____

☐ Poster (Where?) _____

☐ Mail ☐ Website ☐ Approached by Staff ☐ Information Stall ☐ Radio/TV

☐ Other (Please Specify) _____

Do you have any advice/suggestions/feedback on NHW marketing activites? _____

_____

_____

Please note that NHW does not provide financial incentives for referrals, however we do encourage you to tell your friends about us. Please let us know if you would like some material you can pass on. Alternatively, if there is someone you believe we should call, please feel free to list their names and contact details here: _____

_____

_____

_____

Personal Health History

Please fill out the following questionnaire. Please do not feel embarrassed by how much or how little you put down, please just do your best to give an accurate report of where your health is at right now. This will help us to provide you with better care, and it will help you to track your health as it improves.

Healthcare Outcomes

Which areas are you looking for care in?

- ☐ Physical Symptom Relief
- ☐ Emotional/Mental Symptom Relief
- ☐ Improved Health/wellbeing
- ☐ Reduced Tension/Flexibility
- ☐ Improved Stress Management
- ☐ Children - Behavioural
- ☐ Children - Developmental
- ☐ Improved Posture
- ☐ Greater Energy Levels
- ☐ Quality of Life

Primary Complaint

Please note any issues that are of particular concern here

What is your main area of concern?_____

_____

_____

When did this problem start?_____

Do you know what caused the problem?_____

What makes it better?_____

What makes it worse?_____

How often do you have symptoms? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasional

Have you had other treatments?_____

Are there any other major issues you would like help with, or that your practitioner should know about?_____

_____

_____

_____

_____

_____

Current Health Scores and History

Do you experience any of the following? (P=past, C=current)

P	C		P	C	
☐	☐	Low back pain	☐	☐	Difficulty falling asleep
☐	☐	Neck pain	☐	☐	Difficulty staying asleep
☐	☐	Tension across top of shoulders	☐	☐	Anxiety/Depression
☐	☐	Headaches	☐	☐	Blood Sugar handling Problems
☐	☐	Migraines	☐	☐	Cholesterol problems
☐	☐	Vision problems	☐	☐	Poor circulation
☐	☐	Fatigue/low energy	☐	☐	Colds and flu
☐	☐	Accidents/near accidents/tripping	☐	☐	Recent loss or gain in weight
☐	☐	Weight changes (recent gain/loss	☐	☐	Nausea
☐	☐	Ringing in ears	☐	☐	Poor Digestion
☐	☐	Difficulty concentrating, thinking	☐	☐	Indecisiveness
☐	☐	Recurring thoughts or dreams	☐	☐	Fidgety or restless; difficulty sitting still
☐	☐	Trouble talking	☐	☐	Diarrhoea or Constipation
☐	☐	Difficulty Breathing	☐	☐	Hormonal problems
☐	☐	Heart condition	☐	☐	Skin problems
☐	☐	Osteoporosis			**FOR WOMEN**: Are you pregnant? Y N
☐	☐	High or low blood pressure	☐	☐	Irregular menstrual periods
☐	☐	Stress with daily activities	☐	☐	Painful menstrual periods
☐	☐	Poor Balance/Co-ordination	☐	☐	Premenstrual mood swings/tension
☐	☐	Poor/Variable muscle strength	☐	☐	Endometriosis/fibroids

Please List All allergies:_____

_____

_____ ☐ None

Please Score your current Health Performance (Please Circle):

	Bad	Poor	Average	Good	Excellent	Not Sure
Presence of physical pain	1	2	3	4	5	O
Energy	1	2	3	4	5	O
Handling Stress	1	2	3	4	5	O
Fitness	1	2	3	4	5	O
Performance at Work	1	2	3	4	5	O
Self-Image	1	2	3	4	5	O
Depression	1	2	3	4	5	O
Relationships (Personal)	1	2	3	4	5	O
Relationships (Professional)	1	2	3	4	5	O
Sex Life	1	2	3	4	5	O
Self-Confidence	1	2	3	4	5	O
General well-being	1	2	3	4	5	O
Emotional well-being	1	2	3	4	5	O
Coping with daily problems	1	2	3	4	5	O

Feelings of Joy/Happiness	1	2	3	4	5	O
Time spent on fun activities	1	2	3	4	5	O

Rate the following:	**None**	**Slight**	**Moderate**	**Pronounced**	**Extensive**	**N/A**
Experience of relaxation or ease	1	2	3	4	5	O
Positive feelings about yourself	1	2	3	4	5	O
Interest in healthy lifestyle	1	2	3	4	5	O
Feeling of being open and aware/connected when relating to others	1	2	3	4	5	O
Level of confidence in your ability to deal with adversity	1	2	3	4	5	O
Level of compassion for, and acceptance of, others	1	2	3	4	5	O
Satisfaction with the level of recreation in your life	1	2	3	4	5	O
Feelings of joy or happiness	1	2	3	4	5	O
Time devoted to things you enjoy	1	2	3	4	5	O

Rate the following questions with respect to frequency:	**Never**	**Rarely**	**Occasionally**	**Regularly**	**Constantly**	**N/A**
If pain is present, how distressed are you about it?	1	2	3	4	5	O
Presence of negative or critical feelings about yourself	1	2	3	4	5	O
Experience of moodiness or temper or angry outbursts	1	2	3	4	5	O
Experience of depression or lack of interest	1	2	3	4	5	O
Being overly worried about small things	1	2	3	4	5	O

Physical Stresses

Please list any major physical traumas you have had (falls, broken bones), along with the approximate date they occurred _____

_____

_____

_____

_____

_____

Please list any scars_____

_____

_____

_____

_____

Chemical Stresses

Please list any medications you are currently taking (including panadol)

Past medications

Have you been exposed to any major chemical toxins (amalgam fillings, petrochemicals, agricultural chemicals etc.)

Please provide a brief summary of your diet, including chemicals and foods including artificial sweeteners, preservatives, refined and processed foods.

How many cups of water do you drink a day?

Emotional Stresses

Please list any major emotional issues you may have experienced since birth, along with age of each event. Include changes in lifestyle, home situation, relationship breakups, abuse, violence, traumatic events etc.

List any emotional issues that you might be dealing with now:

Is there anything else we should know?

Informed Consent Form

Patient Information

Chiropractic care is recognised as being an effective and safe method of care for many conditions. Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A risk Assessment of Cervical Manipulation, JMPT, 1995. Manga report, Ontario Ministry of Health, 1993)

There are risks associated with all health care procedures which you should be informed about, and changes to the law now require all practitioners who adjust (manipulate) the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approximately 1 in 5.85 million neck manipulations, Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000).[Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.] Please note the may be considerable degree of variation in individual response to chiropractic care.

Consent to Chiropractic Care

The procedures to be used in your case will be described after which you will be asked you have any questions. After speaking with the chiropractor we request that you sign below as your consent to proceed is required.

Patient's signature_____ Print name _____
(Parent or Guardian to also sign if patient is under 18)

Chiropractor's signature _____ Date_____