ADULT CONFIDENTIAL PATIENT CASE HISTORY

(PLEASE PRINT)

Name: ____ Date: _____________________

Address: ____________________ Town/Suburb: _______________ Postcode: _____________

Telephone – Home: ____________ Business: _____________ Mobile: _____________________

Email address: ____

Date of Birth: ______________________ Age: ____________ Sex: Female Male

Occupation: ____________________________ Exercise/Sports __________________________

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed

Spouse's name: _______________ No. and ages of children ______________________________

How many of your immediate family members attend our clinic? _____________________________

Are you in a private health fund? _________ Are you covered for Chiropractic? Y N

Is this a Worker's Compensation Case / Third Party? Y N

How did you hear about our clinic?

Friend or acquaintance Name: ______________________

Family member Name: ______________________

Another health professional Name: ______________________

Other ____

Have you ever received Chiropractic care? Y N

Name of previous Chiropractor and approximate date of last visit: ____________________________

Yes	No	
☐	☐	Have you ever had any majors accidents, been in hospital or had any major surgery or illness? If so, please explain:
		____
		____
☐	☐	Have you ever had x-rays or any other imaging done? If so, which area/s? ___________

____

PRESENT STATE OF HEALTH

What is your present complaint? ____

____

How long have you had this complaint? ____

Was there an accident that caused this? ____

Do you feel any pain? Y N

If so, what type of pain? Sharp Dull Burning Constant Intermittent

Is there any pain if you cough, sneeze or have a bowel motion? Y N

Does the pain wake you up at night? Y N

Is the complaint / pain getting progressively worse? Y N

Have you had this, or a similar complaint/s in the past? Y N

What aggravates your complaint? ____

What relieves your complaint? ____

Are there any other symptoms you feel? ____

Doctor/OB/GYN/ Health Care Professional Details _____________________________________

If so, please give details & any treatment received _____________________________________

____

Are you taking any medication or supplements for this or any other problem? ________________

____

Average Alcohol Consumption per week________Do you smoke? Y N

Your Health Objectives:
People consult this practice with one or more of the following health objectives. Please indicate which apply to you:

For relief of my symptoms only
For correction of the underlying causes of my symptoms and health problems
To prevent the development of symptoms, health problems and degeneration
To achieve an optimal level of health and well being

What is the problem interfering with for you?____

____

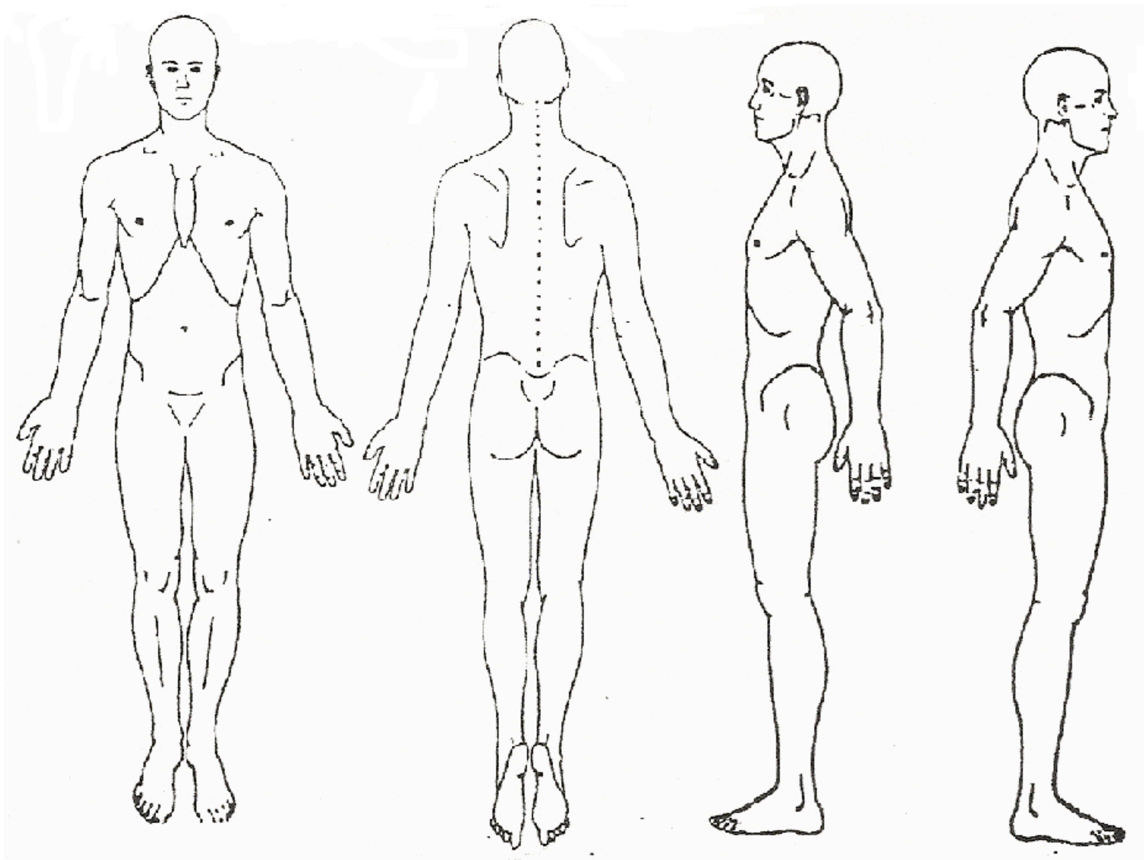
Do you now have, or have you ever suffered from any of the following problems?
If so, please explain:

Frequent headaches ___________________
High blood pressure ___________________
Diabetes _____________________________
Asthma or Respiratory Problems ________
Anaemia _____________________________
Scoliosis _____________________________
Fainting/dizziness ____________________
Numbness/tingling in arms ____________
Numbness/tingling in legs ____________
Recurrent infections___________________
Balance or Co-ordination difficulties_____
Tremors/Tics/ twitches_________________

Heart/chest problems _________________
Digestive problems ___________________
Menstrual problems __________________
Arthritis ____________________________
Osteoporosis ________________________
Fatigue_____________________________
Cancer _____________________________
Kidney/bladder problems ______________
Depression/Anxiety/Stress _____________
Poor Sleep__________________________
Hearing changes or ringing in ears_______

Allergies (including allergies to medications) ____
Other ____

If relevant for your problem, please mark on the diagram below where your complaint areas are:



Other details you wish to include:

____

PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

PATIENT INFORMATION

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation.

2) I appreciate that **positive results of any treatment** that I receive at NeuroBalance Chiropractic **is not guaranteed**. I understand that the team at NeuroBalance does not aim to treat my symptoms, but address any dysfunction identified.

3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

4) Information gained from the initial assessment and follow up sessions **may be used for internal research purposes** or **publishable research** to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details etc.) will be disclosed in any published material.

Risks of Care & Consent for Care:

5) Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications.** This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.

6) I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.

7) I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

____

Name **Date**

____

Signature (if patient is under 18 parent signature and name)