Tasman Bay Chiropractic

HEALTH HISTORY– CONFIDENTIAL

Personal Details

Dr/Mr/Mrs/Miss/Ms Given Names:_____ Surname: _____

Address:_____

_____ Postcode: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ *E-mail: _____

Emergency Contact (EC) Details: EC Name: _____

EC Phone: _____ Your relationship with EC:_____

Your Birth Date: _____ Age: _____

Occupation: _____ Duties:_____

Partner's name: _____ No. of Children: _____

Are you covered for chiropractic care by health care insurance? Yes [ ] No [ ]

If Yes, by whom? _____

Is this an ACC Claim? Yes [ ] No [ ] Ethnicity _____ (for ACC)

Who is your regular doctor (General Practitioner)? _____

We are grateful that our practice grows by referral. How did you hear about us? Who may we thank for referring you? _____

Have you ever seen a chiropractor before?

Yes [ ] Who did you see and when was your last visit? _____

_____

No [ ] We will explain everything as we go and only proceed once you are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating the function of your spine and nervous system.

**will be used to send our quarterly newsletter to and for correspondence regarding your care*

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Please circle the purpose for your visit today: crisis management/prevention/ wellness/ early detection of problems/maximizing normal growth and development

If the purpose of your visit today is wellness care please go to page 4 – Medical History and General Health section.

Major Health Concern

What is your main issue? _____

_____

When and how did it start? _____

Was there any of the following prior to or during the onset? (Please circle)

Illness/infection Trauma/accident Other significant event

Please describe _____

Is your problem getting better, worse or does it come and go? _____

What relieves your symptoms? _____

_____

What makes your symptoms worse? _____

_____

Are your symptoms worse at night or any specific time of the day? _____

_____

Do you have any pain traveling down your arms or legs? Yes/No If yes, describe _____

_____

Does your current problem involve any of the following? If yes, where?

- Tingling in either arm or leg Yes/No _____
- Numbness in either arm or leg Yes/No _____
- Weakness in either arm or leg Yes/No _____
- 'Weird' sensations in either arm or leg Yes/No _____
- Have you had any other treatment for your current problem? Yes/No _____

  _____

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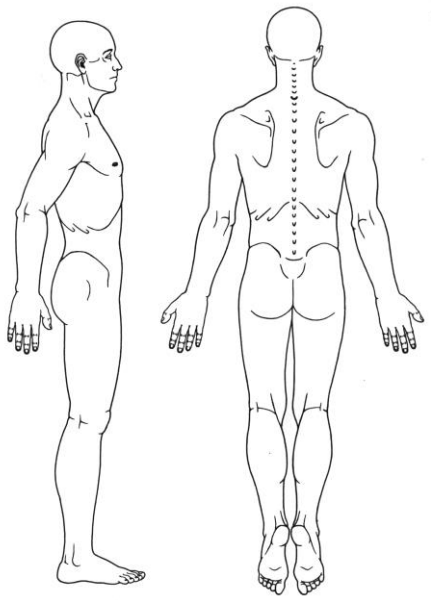
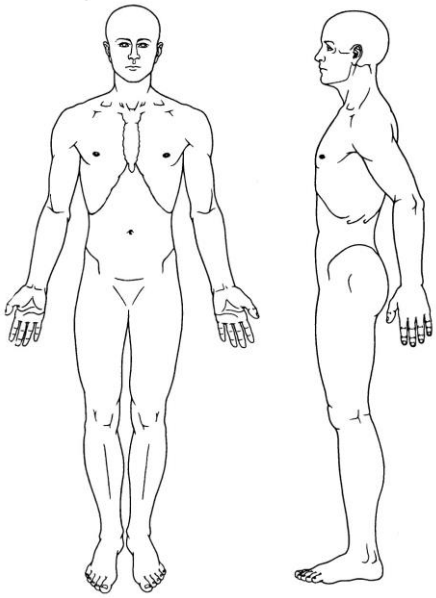
Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.

Please indicate if appropriate, with an *x*, the level of pain on the scale below and the nature – ie: sharp; searing; dull; intermittent; constant etc.

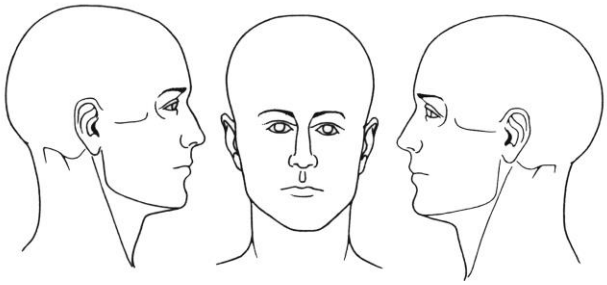




Pain: ——|——————————|——————————|——

No pain Worst pain of your life

Nature of the pain: _____



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Medical History and General Health

Please circle Yes or No where applicable:

Have you had any form of surgery? Yes/No If yes, where and when? _____

_____

Are you currently taking any form of medication? Yes/No If yes, please list all of them and state the reason for taking them _____

_____

Do you, or have you ever had, a serious health problem such as high blood pressure, heart disease, diabetes, arthritis or any form of cancer? Yes / No. If yes, please specify._____

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease, high blood pressure, stroke, arthritis or any other major health problem) Yes/No

If yes:_____

_____

Have you broken any bones? Yes/ o If yes, which ones and how? _____

_____

Have you had any motor vehicle accidents (no matter how trivial)? Yes/No If yes, when and describe

_____

Have you had any falls or sports injuries? Yes/No If yes, when and describe _____

_____

Did / Do you smoke? For how long? Yes/No _____

Did / Do you drink alcohol? Yes/No _____

Did / Do you take recreational drugs? Yes /No _____

Do you think you have a healthy diet? Yes/No _____

Do you take any supplements? Yes / No If yes, what:_____

_____

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Please indicate which of the following your chiropractor should discuss with you:

[ ] exercise

[ ] pregnancy

[ ] fatigue

[ ] sleep

[ ] depression

[ ] dizziness/balance

[ ] bowel/bladder/digestion

[ ] change in weight greater than 4kgs (in last year)

Any other comments or health related issues that you feel your chiropractor should know about?

_____

_____

_____

Our practice specialises in managing functional problems and associated disorders of the nervous system with a focus on neuro-musculoskeletal complaints. A proportion of our patients come via referral from their medical practitioner and/or from a previous chiropractor. As such, it is standard practice to correspond with your medical practitioner where appropriate and/or to request your notes and any x-rays from your previous chiropractor.

Please complete the following:

☐ I give consent for my clinical information to be communicated to my general practitioner and/or another registered health provider where appropriate.

☐ I give consent for Tasman Bay Chiropractic to request notes and any xrays from my previous chiropractor(s).

_____
(Signature)

_____
(Print Name)

_____
(Date)

CONSULTATION AND EXAMINATION

H.H.

Lifestyle ☐ NTR

Radiation History ☐ NO ☐ YES

Previous Treatment ☐ NO ☐ YES

Handedness ☐ L ☐ R **B+B** ☐ NTR ☐ YES ☐ MAIGNES

FAMILY HISTORY

☐ Cancer ☐ Arthritis ☐ NTR

☐ Heart / Vascular disease ☐ Diabetes ☐ Serious illness

Standing — RE EX

	L	R	L	R	L	R
C. Rotation 70⁰						
C. Flex 45⁰						
C. Ext 45⁰						
Kemp's C						
C. Lat Flex 40⁰						
Trunk Flex 90⁰						
Trunk Ext 30⁰						
Kemp's L						
Trunk Lat Flex 35⁰						
Trunk Rot 30⁰						
Serratus Antr						
Deltoid						
Supraspinatus						
Opponens						
Latisimus						
Rombergs						

Weight						
Height						
BP						
Pulse						

Sitting

Upper Traps						
Scalenes						
C. Compression						
Jacksons						
Valsalva						
SLR Sitting						
Brachioradial C 5, 6						
Biceps C 5, 6						
Triceps C 7, 8						
Patella L 2, 3, 4						
Ankle S 1, 2						
Babinski						

Supine — RE EX

	L	R	L	R	L	R
Psoas						
Quadriceps						
Piriformis						
Neck Flexors						
Pectoralis						
Abdominal						
SLR						
Fabere Patrick						
SOT Cervical						

Prone

Derifield						
Elys						
Hamstring						
Gluteus						
Leg / Hip Extension						
Neck Extensors						

PATIENT

L	0	R
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1	
	2	
	3	
	4	
	5	
	S	

CHIRO

L	0	R
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1	
	2	
	3	
	4	
	5	
	S	

TOTAL + VE TESTS

EXAM ☐ Date:

☐ Date:

☐ Date: