MMC
Mid-Murray Chiropractic

"Optimal Health through Progressive Chiropractic Care"

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us to determine if Chiropractic can help you.

Mr,Mrs,Ms,Miss,Dr *(First Name)*…….…….. *(Surname)* ……..……
Address……Postcode ……..
Postal Address *(if different)* ……..…
Tel:Home……..……Office……Mobile …….
Email: …… Occupation ……...
Birthdate……..……Marital Status……...…… Children …….
Medicare Card Number…… Pension/Concession Card: Yes / No
Reference Number …… Private Health Insurance: Yes / No
How did you find out about Mid-Murray Chiropractic? *(please tick)*
Yellow Pages □ Advertising □ Signage □ Relative/friend □ Name: ..……...……
Do you give permission for us to send a thank you to your referrer? Yes / No

HEALTH HISTORY:

What, if any, are your present symptoms?
……..……
…….……..…..
……..……
……..……
……..……

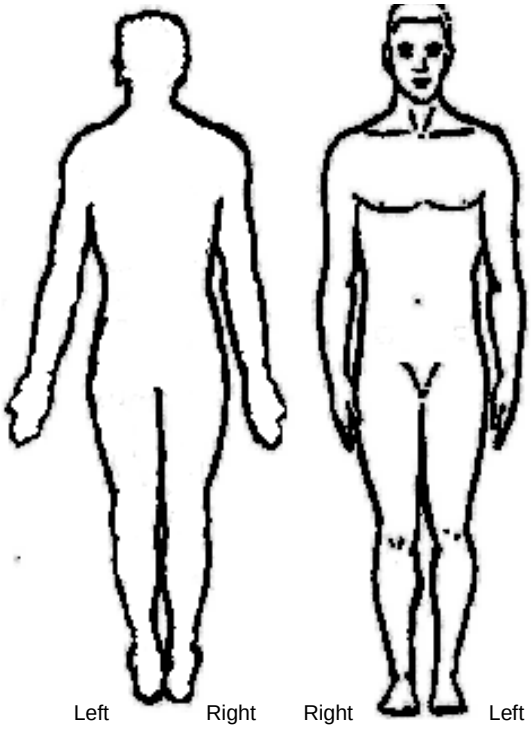
Original onset date ……..…….……
……..……

Caused by *(if known)* ……..……
……..……
……..……

Previous treatment by ……..……
……..……
Result ……..……
……..……

Have you received chiropractic care before?
Yes □ No □If yes, which Chiropractor?
……..……

PLEASE ILLUSTRATE AFFECTED AREAS



Were chiropractic postural X-Rays taken? Yes □ No □

If Yes, approximately when. ……..……

Office Use Only

Patient Name: **Date of Birth:**

Please list or describe:

Are you currently taking any medications?

……..……

……..……

Natural Supplements ……..……...

……..……..

Please list or describe:

What is your daily water intake? ……..…

What does your diet consist of? For example, do you eat fruit/veg/take-out?……..

……

Do you exercise? YES □ NO □

How often and for how long?……

Have you/ do you suffer/ experience a lot of stress in your life? YES □ NO □

Have you had any of the following? (please describe)

Fractures ?……..

Falls ?……

Major Illnesses?……..

Surgeries/Operations?……...

Been hospitalised?……

Vaccinations? Any Reactions?……..……..

Have you suffered or do you suffer from any of the following? *(Tick appropriate box)*

□ Pins & Needles of Hands	□ Scalp Disorders	□ Asthma
□ Loss of Grip	□ Pain in Head	□ Chronic Cough
□ Wrist or Hand Pain	□ Soreness in Neck	□ Stomach Tension
□ Mid Back Pain	□ Shoulder Pain	□ Digestive Malfunction
□ Mid Back Tension	□ Shoulder Stiffness	□ Nausea
□ Pain in Ribs	□ Shoulder Tension	□ Allergies
□ Low Back Pain	□ Arm Pain	□ Vomiting
□ Low Back Weakness	□ Elbow Pain	□ Constipation
□ Low Back Stiffness	□ Loss of Arm Power	□ Diarrhea
□ Hip Pain or Stiffness	□ Eye Disorders	□ Abdominal Pain
□ Buttock Pain	□ Loss of Taste	□ Piles
□ Leg Pain	□ Headaches	□ Urinary Disorders
□ Leg Cramps	□ Nervousness	□ Bed Wetting
□ Pins & Needles of Legs	□ Insomnia	□ Menstrual Disorders
□ Knee Trouble	□ Dizziness	□ Loss of Potency
□ Foot or Ankle Trouble	□ Loss of Smell	□ Other Sexual Disorder
□ Pins & Needles of Feet	□ Sinus Trouble	□ Tension Chronic
□ Ear Disorders	□ Recurrent Sore Throat	□ Irritability Chronic
□ Hay Fever	□ Sleeping Problems	□ Fatigue Chronic

Office Use Only

Patient Name: **Date of Birth:**

YOUR HEALTH GOALS:

Please identify the three things currently most important to you in your life:

i) _____ ii) _____ iii) _____

Which of the following would you like to achieve? *(Please tick)*

- ☐ More Energy
- ☐ Better Concentration
- ☐ Improved Digestion
- ☐ Easier breathing / deeper breaths
- ☐ Deeper relaxation
- ☐ More balanced posture
- ☐ Better sleep
- ☐ Enhanced emotional wellbeing
- ☐ Improved strength and endurance
- ☐ Better sports performance, reaction time / reflexes
- ☐ Freedom from pain
- ☐ Reduce / eliminate use of medication
- ☐ Greater resistance to disease
- ☐ Overall health improvement

I understand that Mid-Murray Chiropractic <u>does not offer accounts</u>, and that payment is expected at the time of my visit. I agree to adhere to these terms. I also confirm that the above information about my health is true and correct to the best of my knowledge.

Signature…….…… Date……

Mid-Murray Chiropractic welcomes all feedback. We use complaints, suggestions and compliments as a method of continually improving our service performance, systems and processes to ensure delivery of effective and quality services to all of our patients.
Feedback and complaints as well as compliments, are accepted verbally, in writing, via the form available at reception, by email, fax or any other communication method.

CONSENT TO X-RAY & TO EXAMINATION AND CHIROPRACTIC CARE

Patient Name: _____ **Date of Birth:** _____

Changes to the law now require all practitioners who take x-rays and adjust the spine to inform patients of material risks.

The Risk Associated with Chiropractic Care

In extremely rare circumstances, chiropractic care of the neck may damage blood vessels and give rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments are required, you will be tested beforehand, as has always been our practice (i.e. check for dizziness, referred pain, etc). 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).

Chiropractic adjustments of the spine are internationally recognized 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, 1994. Manga Report, Ontario Ministry of Health, 1993). If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to your chiropractor.

The Risk Associated with X-ray

Generally, the benefit of the X-ray procedure is far more important than the small estimated risk. At the radiation dose levels that are used in diagnostic radiography there is little or no evidence of adverse health effects. There are two major risks to health that occur as a result of exposure to medical ionizing radiation (which is the kind of radiation in X-rays). These are cancer occurring many years after the radiation exposure and health problems in the children born to people exposed to radiation because of damage to the reproductive cells in the body. Medical research has as yet been unable to establish conclusively that there are significant effects for patients exposed to ionizing radiation at the doses used in diagnostic imaging. In addition, the dose of radiation that you receive from X-rays is very much lower than for other types of radiology procedures such as Computed Tomography (CT) scanning or angiography (X-ray examination of the blood vessels).

To put this all into perspective, a patient would need to have approximately 38 chest X-rays to receive an amount of radiation similar to that of normal background radiation that everyone receives for one year from the environment (ARPANSA 2008). This is very encouraging and supports the use of the small doses involved in diagnostic radiography.

What are the benefits of X-rays?

The benefits of X-ray are:
X-ray imaging is useful to diagnose disease and injury fractures, bone infections, arthritis, etc.
X-ray imaging is fast and easy so it is particularly useful in emergency diagnosis and treatment.
X-ray equipment is relatively inexpensive and widely available in hospitals and X-ray clinics and other locations, making it convenient for both patients and doctors, even in remote locations.

☐ I consent to Chiropractic Care any X-rays that may be required and state that I have read and understood the possible risks involved.

☐ If I am female I certify that I am not pregnant.

Patient Signature: _____ **Today's Date:** _____

(Parent or guardian signature required if under 15 years old).

Chiropractor's Signature: _____