CONFIDENTIAL PATIENT INFORMATION

25+ YEARS NEWCASTLE AND CITY CHIROPRACTIC CLINICS
25+ YEARS OF LOOKING AFTER THE HEALTH OF YOUR SPINE

Welcome to our clinic!

*Please complete all questions and **PRINT** clearly. All the information you provide remains confidential to this clinic* ***DATE*** ....

Surname:		First Name:	
Address:		Town:	
		Post Code:	
Home Phone:	Mobile Phone:		Work Phone:
Date of Birth:		Email:	
Marital Status: Partner's name:			
Children's names and ages:			
Occupation:		Employed by:	
How did you hear about the practice?			
Type of work: Sitting ☐ Computer ☐ Telephone ☐ Standing ☐ Driving ☐ Lifting ☐ Other _________			

What brings you into our practice?

Please list your **chief complaints** in order of severity.

1. ____ When did **this episode** start? ____________________

Rate the **severity** of your pain on a scale from 0 to 10: **No Pain** - 0 1 2 3 4 5 6 7 8 9 10 - **Unbearable Pain**

What percentage of the time is your pain present? **No pain** 0 10 20 30 40 50 60 70 80 90 100% **Constant Pain**

2. ____ When did **this episode** start? ____________________

Rate the **severity** of your pain on a scale from 0 to 10: **No Pain** - 0 1 2 3 4 5 6 7 8 9 10 - **Unbearable Pain**

What percentage of the time is your pain present? **No pain** 0 10 20 30 40 50 60 70 80 90 100% **Constant Pain**

3. ____ When did **this episode** start? ____________________

Rate the **severity** of your pain on a scale from 0 to 10: **No Pain** - 0 1 2 3 4 5 6 7 8 9 10 - **Unbearable Pain**

What percentage of the time is your pain present? **No pain** 0 10 20 30 40 50 60 70 80 90 100% **Constant Pain**

Have you ever been to a **chiropractor** before? YES ☐ NO ☐ If YES, when? ______________________________________

Please list the **doctors or therapists** who were consulted for these conditions and diagnosis you were given:

Any other issues?

Please tick if you have had any of the following:

☐ Low back pain
☐ Neck pain
☐ Shoulder Pain
☐ Leg pain
☐ Migraines
☐ Headaches
☐ Arthritis
☐ Osteoporosis
☐ Dizziness
☐ Low energy / Fatigue
☐ Seizures / Fainting
☐ Heart disease
☐ Stroke
☐ Hot flushes/ fevers
☐ Allergies
☐ Menstrual pain / Irregularity
☐ Low pain threshold
☐ Frequent Colds/infections
☐ Anxiety/ Nervousness
☐ Depression
☐ Irritability
☐ Mood swings
☐ Poor concentration
☐ Diabetes
☐ Respiratory problems
☐ Cancer
☐ Skin disorders
☐ Digestive problems
☐ Ulcers
☐ Bladder problems
☐ Cold hands / feet
☐ High Blood Pressure

General history

Name and address of current GP: ___________________________ Date of last physical: _______________

Females only: Is there any possibility that you are **pregnant**? YES ☐ NO ☐ Date of last period: ___________

I give my consent for the clinic to contact or write to my GP about my condition or in case of emergency or if clinically indicated. **Sign**___________

Please list any **operations** you have had (and ages):

1. ____________________________ 2. ____________________________

Please list any serious **illnesses** you have had (and ages):

1. ____________________________ 2. ____________________________

Are you currently taking **medications** (including the contraceptive pill)? If yes, what type and what for?
____

Has anyone in your immediate family ever suffered from: Cancer, Hepatitis, Diabetes, Epilepsy, Tuberculosis,

Rheumatoid Arthritis or Vascular disease? Details ____

Do you **smoke**? YES ☐ NO ☐ If YES, how many per day? __________ For how many years? __________

Do you **drink alcohol** YES ☐ NO ☐ If YES, what type and how many glasses per week? ___ For how many years?

Do you take part in any **regular exercise**? YES ☐ NO ☐ If YES, how often and what type? ______________________

How much water do you drink each day? _________Glasses ______ Litres

What are your **Hobbies**:____

Your Health Goals

- Are you happy with the way you feel? **Unhappy** 1 2 3 4 5 6 7 8 9 10 **Very Happy**
- How long has it been since you have felt your best? YEARS MONTHS DAYS
- How long have you been thinking about pursuing your health goals? YEARS MONTHS DAYS
- What are you most interested in improving?
- How long do you think it will take to achieve your health goals? YEARS MONTHS DAYS

What is the most important thing that your condition prevents you from doing? _________________________

General pain disability index

We would like to know how much your pain is preventing you from doing what you would normally do. Respond to each category indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE CIRCLE EACH ACTIVITY WITH A SCORE OF 0-10 WHICH BEST DESCRIBES YOUR TYPICAL LEVEL.

A score of **0** signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain and a score of **10** means no limitation at all.

1. Family/Home Responsibilities - Chores and duties performed around the house (eg. gardening, housework, shopping) **Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able**

2. Recreation - Hobbies, sports, and other similar leisure time activities.
Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able

3. Social Activity-Participation with friends and family. Parties, theatre, concerts, dining out and other social functions. **Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able**

4. Occupation - Directly related to your job. Full, part, or non-paid positions; including homemaker.
Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able

5. Self Care - Personal maintenance and independent daily living (eg. Taking a shower, driving, dressing, etc.)
Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able

6. Life-Support Activity - Eating, sleeping, and breathing.
Total limitation – 0 1 2 3 4 5 6 7 8 9 10 - Very able

HOW TRUE ARE THESE STATEMENTS BELOW

7. It's not really safe for a person with a condition like mine to be physically active
Very True – 0 1 2 3 4 5 6 7 8 9 10 - Not True at all

8. Worrying thoughts have been going through my mind a lot of the time
Very True – 0 1 2 3 4 5 6 7 8 9 10 - Not True at all

9. I feel that my (back, neck) pain is terrible and is never going to get any better
Very True – 0 1 2 3 4 5 6 7 8 9 10 - Not True at all

10. In general I have not enjoyed all the things I used to enjoy
Very True – 0 1 2 3 4 5 6 7 8 9 10 - Not True at all

Clinic use Total:

General Wellbeing

CLINIC USE

Rate yourself for each of the following:

How well do you **Sleep**?	**Hardly**	1	2	3	4	5	6	7	8	9	10	**Well**
How are your **Energy** levels?	**Very Low**	1	2	3	4	5	6	7	8	9	10	**Excellent**
How **Stressed** are you?	**Extremely**	1	2	3	4	5	6	7	8	9	10	**Not at all**
How are you **Concentration** levels?	**Poor**	1	2	3	4	5	6	7	8	9	10	**Excellent**
How good is your **Bowel Function**?	**Poor**	1	2	3	4	5	6	7	8	9	10	**Very Good**
How has your pain affected your **Appetite?**	**Badly**	1	2	3	4	5	6	7	8	9	10	**Not at all**
What is your **Mood** like?	**Poor**	1	2	3	4	5	6	7	8	9	10	**Very good**
Does your **Immune System** function well?	**Poor**	1	2	3	4	5	6	7	8	9	10	**Excellent**
How **Irritable** are you?	**Extremely**	1	2	3	4	5	6	7	8	9	10	**Not at all**
How good do you think your **Posture** is?	**Poor**	1	2	3	4	5	6	7	8	9	10	**Excellent**

DECLARATION: This information is true and accurate to the best of my knowledge.

Patient Signature: ________________________ Date: ____________