CONFIDENTIAL HEALTH HISTORY FORM

The following information is confidential and will assist us in determining your current level of health.

Title

First Name_____Surname_____

Address

_____

Suburb _____ Post Code_____

Email _____

Phone (hm)_____ (mob) _____

Date of Birth____ / ____ / ____ How were you referred to Biomax? _____

Spouse/NOK_____ Your Occupation_____

Do you have children, if so how many? _____

Your General Practitioner _____ Phone#_____

When did you last see a Chiropractor? _____Date of last Chiropractic x-rays _____

List any medications/ drugs you are currently taking, the reason and the dosage:

_____

_____

Please List any surgeries you have had and approx date:

_____

_____

_____

_____

Main Areas of Concern: Primary Problem

Please describe: _____

How old were you when this problem started? _____

Do you know what caused it? _____

What previous treatment have you had? _____

What makes the problem better? _____

What makes it worse? _____

On a scale of “0” being nothing and “10” being severe, how would you rate the problem?

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Is the problem daily / weekly / occasional / other? _____

Do you get any referred pain? YES / NO

If Yes where? _____

Secondary Problem (if any)

Please describe: _____

How old were you when this problem started? _____

Do you know what caused it? _____

What previous treatment have you had? _____

What makes the problem better? _____

What makes it worse? _____

On a scale of “0” being nothing and “10” being severe, how would you rate the problem?

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Is the problem daily / weekly / occasional / other? _____

Do you get any referred pain? YES / NO

If Yes where? _____

The spine can become misaligned over time from accidents, traumas, poor posture and ongoing stress.

Please list the main traumas your spine has been subjected to, your age when the trauma occurred and the severity of the trauma. Don’t forget your childhood falls, sports injuries, car accidents and broken bones.

Trauma	Age	Severity 0-10

It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. When the blood vessels are damaged or deteriorating there are several key symptoms that indicate less blood flow is occurring to the head. Have you recently experienced any of the following:

Unsteadiness on your feet or Severe Dizziness YES / NO

Difficulty Talking or Swallowing YES / NO

Unrelenting Nausea or Vomiting YES / NO

Severe Headaches or Neck Pain Unlike Ever Before YES / NO

Ringing in the ears or Recent Visual Changes YES / NO

Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine.

Have you recently experienced any of the following:

Loss of bowel or bladder control YES / NO

Loss of leg muscle size or numbness in the legs YES / NO

Difficulty standing up or progressive weakness in the legs YES / NO

Shooting or sharp pain in the low back or legs when coughing or sneezing YES / NO

General Health History

Please circle YES or NO to the following questions:

Any history of bone thinning disease such as osteoporosis, or long term use of cortcosteroids?

YES / NO

Please list ANY health problems you may have (eg; Diabetes, asthma, cancer, high blood pressure etc)

.....
.....
.....

Any recent unexplained large loss of weight? YES / NO

Do you give permission for us to share your case information with your immediate family? YES / NO

Do you give permission for us to share your case information with your GP? YES / NO

Female only (FOR x-RAY PURPOSES): Is there any chance of you being pregnant YES / NO

Signature_____ Date____ /____ /____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Scope of care: Chiropractic care is focused on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercise, traction devices, shoe lifts or other to help the spinal corrections.

Medication: Many patients experience great health improvements beyond spinal improvement and it is common for patients to report changes in medical health conditions. However, changes in medications or management of medical conditions needs to be done by your GP or specialist. Chiropractors cannot advise you as to your medical needs.

Alternatives To Chiropractic Care: If a patient does not wish to correct the spinal alignment and function then the alternatives are pain relief care with other health professionals or care designed to stabilise the spine such as core exercise.

Risks of Not Undergoing Care: Spinal problems may get worse if uncorrected or not managed and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and even general health.

RISKS TO PATIENTS: All types of care have associated risks and it is important that a patient accepts these before undergoing care. Adjustments require forces to move spinal bones and as such put stresses on blood vessels, bones, discs, nerves and soft tissues. The below are some of the more serious and more common risks but it is not an exhaustive list.

a) **RARE BUT SERIOUS RISKS**: damage to the blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury. b) More Common but less serious: Sprains, strains, rib fractures, bruising, inflammation and soreness.

Pregnancy Release: X-rays can be hazardous to an unborn child. In signing below I consent to x-rays evaluation and certify (if female) that to the best of my knowledge I am not pregnant.

The Chiropractor has gone through the risks of care and examination; I have been informed of the alternatives to care to my satisfaction. I have had the opportunity to ask any further questions or information from the Chiropractor or to ask for more time before signing the consent to care and examination.

NAME:_____

SIGNATURE:_____

Date:_____