Over 60's Patient History

UMINA CHIROPRACTIC CENTRE

N.B. Your information is handled in line with the current privacy regulations

Date: _____

Surname:		**Date of Birth:**	
Given name / s:			
Gender: □ Male □ Female □ Other		**Marital Status:**	
Year of birth of any children:			
Email Address:			
Residential Address: **Postcode:**			
Home Phone:	**Work Phone:**	**Mobile Phone:**	**Emergency contact Name and Number:**
Private Health Fund:			
GP name and address: **Permission to contact your GP?** □ Yes □ No			
Who may we thank for referring you?	**Have you viewed our website:** www.uminachiropractic.com.au	□ Yes □ No	
Occupation (or past occupation):	**Do you commute?** □ Yes □ No If yes, hours per day: _____ hours		
	How many hours are you seated per day: _____ hrs		

As a courtesy we endeavor to send SMS reminders the day before your appointment, however, please note it is still your responsibility to be aware of your appointment date and time. If this is not appropriate for you, please advise reception. For information on our cancellation policy, please speak to reception staff.

Today I am attending for…

Have you ever seen a Chiropractor before?

Yes □ If YES what for? □ Wellness / lifestyle / nerve system health care

□ Symptom based - neck pain / back pain

No □ Not to worry… We will explain Chiropractic Care to you!!

Please inform us of your short and long term health goals:

_____

_____

CURRENT HEALTH CONCERNS

<table>
<tr><td>What are your current symptoms:</td><td>When did this start?</td><td>How did this start?</td></tr>
<tr><td colspan="3">Have you previously had these symptoms? □ Yes □ No
If so, how long ago: _____</td></tr>
<tr><td>Since starting, have the symptoms:</td><td colspan="2">□ Improved □ Worsened □ Stayed the same?
Please briefly explain: _____
_____</td></tr>
<tr><td rowspan="3">What treatment / s have you tried:</td><td colspan="2">Has this helped the condition? □ Yes □ No
Please explain: _____</td></tr>
<tr><td colspan="2">What else improves / worsens the condition:</td></tr>
<tr><td colspan="2">What does this condition affect:
□ Work □ Sleep □ Sports □ Daily routine □ Exercise
□ Other _____</td></tr>
<tr><td colspan="3">Please rate the intensity of your symptoms:
0 1 2 3 4 5 6 7 8 9 10
Best Worst</td></tr>
</table>

Describe your current Symptoms:

□ Sharp

□ Dull

□ Ache

□ Throbbing

□ Tingling

□ Numbness

□ Shooting pain

□ Other _____

Please indicate on the diagram below where your symptoms are:

Pain = X

Tingling/numbness = ///

Shooting/Radiating = >>>

HEALTH HISTORY

Are you regularly screened by your G.P for the following:

□ Bowel Cancer □ Prostate cancer □ Breast Cancer

Please Tick the following conditions YOU have had or have now ***(tick and please write approx. year)***

Please write the year / s on the line provided			
☐ sinus problems _____	☐ miscarriage _____	☐ constipation _____	☐ muscle cramps _____
☐ headaches _____	☐ menstrual cramps _____	☐ obesity _____	☐ anxiety/depression _____
☐ migraines _____	☐ PMS _____	☐ diarrhea _____	☐ excessive stress _____
☐ pneumonia _____	☐ irregular periods _____	☐ thyroid problems _____	☐ insomnia _____
☐ asthma _____	☐ bladder weakness _____	☐ gout _____	☐ alcoholism _____
☐ ringing in ears _____	☐ sexual dysfunction _____	☐ low blood sugar _____	☐ cancer _____
☐ stroke _____	☐ irritable bowel syndrome _____	☐ diabetes _____	☐ multiple sclerosis _____
☐ high blood pressure _____		☐ eczema _____	☐ other _____
☐ heart attack _____		☐ allergies _____	
☐ anemia _____		☐ arthritis _____	

Did you know that poor water consumption is commonly associated with a significant increase in pain?

			Quantity
Alcohol	□ Yes	□ No	_____per week
Tea	□ Yes	□ No	_____per day
Coffee	□ Yes	□ No	_____per day
Water	□ Yes	□ No	_____per day
Soft Drink	□ Yes	□ No	_____per day
Smoke	□ Yes	□ No	□ Previously _____ per day
Recreational drugs	□ Yes	□ No	□ Previously

If yes, what sort and when_____

MEDICAL HISTORY:

Medications / Supplements	Dosage:	How Often:	How long have you been taking it for:

***NB**: If you have a copy of your medication list, please hand to reception on arrival or please list your medications and / or any supplements above.*

Accidents / Injuries / Falls	When and how often:
Illnesses	
Surgeries / Hospitalisation	

FAMILY HISTORY: (please tick)

- □ Stroke
- □ Diabetes
- □ Arthritis
- □ Allergies
- □ Spinal curvature
- □ Genetic disease
- □ Heart / Vascular disease
- □ Cancer
- □ Other_____

LIFESTYLE CONCERNS

Please fill in the information below so that your Chiropractor can assess the accumulation of stressors on the body that affects your health and ability to heal.

On a scale of 1-10 please rate your:

Eating Habits:

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Movement Habits (Eg. exercise, exercising posture & sport)

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Sleeping Habits

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Home Life

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Work / Retirement (please circle the correct one)

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Anxiety /stress regarding your lifestyle (Eg. Finances, relationships, etc)

0 1 2 3 4 5 6 7 8 9 10

High anxiety / stress none

Happiness

0 1 2 3 4 5 6 7 8 9 10

Poor Excellent

Thank you for taking the time to fill in this important information about your health and wellbeing. We look forward to assisting you in achieving your optimum health and maintaining a happy and abundant life.

INFORMED CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, changes to the law now require all chiropractors to warn people of material risks.

As in all health care, there are some risks with chiropractic care. This includes, but is not limited to:

Your condition becoming worse;

- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back);
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments)
- Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs and safer than driving a car.

Some people may experience some mild soreness for 24-48 hours after their adjustments, especially when their body is unwinding. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates ***unexpected improvement*** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health. Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system
- 14%circulatory system/heart;
- 14%eyes/vision.

Paediatric Chiropractic Care. I agree to the Chiropractors at the Umina Chiropractic Centre delivering chiropractic care to minors under my care at my instruction. I understand that these chiropractors are not paediatricians; but are qualified to manage chiropractic care in children. I am also aware that these same chiropractors are members of the Chiropractors Association of Australia and are registered health care practitioners under the AHPRA (Australian Health Practitioners Regulatory Authority). The practitioners maintain their competencies by continuing professional development.

Consent to Chiropractic Care. I do not expect the chiropractor to be able to anticipate or explain **all** the risks and complications. I wish to rely on the chiropractor to exercise his/her judgement during the course of procedures which he/she feels at the time, based upon the information known, is in my best interests.

I understand that the intent of chiropractic care is to assist me in achieving my fullest potential. I also understand that maintenance or wellness care does not rely on the presence of symptoms for its application and monitoring and I have, to the best of my knowledge, provided, the chiropractor with a complete and accurate health history. I have read the above consent. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic examinations, adjustments and other chiropractic procedures wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Signature of Patient:_____ **Print Patients name here:**_____
(or Parent/Guardian if under 18)

Parent/Guardian's name:_____ **Date:**_____

Chiropractor's Signature:_____**Date:**_____