

Centres for Health & Injury Management

CHIROSPO RTS



Leading the Wellness Revolution!

Name: _____ Today's Date: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: Home: _____ Mobile: _____ Business: _____

Email address: _____ Occupation: _____

Date of Birth: / / _____ Health Fund: _____

General Practitioner: _____

GP Address and phone number: _____

Who can we thank for referring to our practice? Friend/Patient, please insert there name
 Yellow pages Sign GP Gym/Personal Trainer

Is This Third Party or Workers Compensation? Y / N Insurer: _____

Spouse/Partners Name: _____

Names and ages of children: _____

Reason for your visit to CHIROSPO RTS: _____

How long has this been of concern to you? _____

Medical History

Over your life accumulated layers of trauma/s are commonly left uncorrected. Uncorrected injuries can leave long standing damage. Lifestyle factors also influence your health over time.

Have you had any:

Y	N	?	Describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports injuries
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle accidents
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prominent Scars
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug (prescriptive, over the counter or other)

Have you ever:

Y	N	?	Describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been knocked unconscious?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Used a cane, crutch or other support?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been treated for spine or nerve disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Had a fractured/broken bone?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been hospitalised?

Do you suffer from:

Y	N	?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Un explained weight loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Disturbing sleep
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats

Suffer or Suffered from any of the following: Please tick relevant

<input type="checkbox"/> Ulcers	<input type="checkbox"/> Measles
<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Anaemia
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Mumps
<input type="checkbox"/> Polio	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Infertility	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Attention Deficit Disorder	

It is well documented that lifestyle factors have a significant influence on your health & wellbeing

Nutritional & Fitness

Meals Skipped	Coffee Daily	Alcoholic Beverages	Do you smoke?	Personal satisfaction with diet
Daily No:	<input type="checkbox"/> 1-2 daily	<input type="checkbox"/> 1-2 daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Highly Satisfied
Weekly No:	<input type="checkbox"/> 3-4 daily	<input type="checkbox"/> 3-4 daily	How many per day?	<input type="checkbox"/> Satisfied
	<input type="checkbox"/> More	<input type="checkbox"/> 1-2 Wkly		<input type="checkbox"/> Unsatisfied
		<input type="checkbox"/> 3-4 Wkly		<input type="checkbox"/> Highly Unsatisfied
		<input type="checkbox"/> More		

What Nutritional Supplementation do you consume?

What exercise do you participate in?

How would you rate your current fitness level? From 1 (Couch Potato) to 10 (Elite Athlete)

Psychosocial

Have any of the following occurred recently?

<input type="checkbox"/> Depression	<input type="checkbox"/> Divorce	<input type="checkbox"/> Drugs/Alcohol increase	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Death of family or friend
<input type="checkbox"/> Change in job status	<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Family Problems	<input type="checkbox"/> Chronic fatigue	
<input type="checkbox"/> Economic stress	<input type="checkbox"/> Increased work stress	<input type="checkbox"/> Other		

Do you suffer from?

General Symptoms

<input type="checkbox"/> Headache	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fever	<input type="checkbox"/> Numbness or pain in arms/legs/hands/feet
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Poor Immunity	<input type="checkbox"/> Chills	<input type="checkbox"/> Allergy (What)

Your spinal and nervous system can have a major influence on the health & wellbeing of your major organs.

Have you had the following?

Gastro-Intestinal	Ear/Nose/Throat	Cardio Vascular	For Women Only
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Earache	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Painful periods
<input type="checkbox"/> Poor digestion	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Irregular cycle
<input type="checkbox"/> Nausea	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Cramps or Backaches
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Are you pregnant
<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Cold hands & feet	
Muscle & Joints	Skin or Allergies	Urinary	Respiratory
<input type="checkbox"/> Weakness	<input type="checkbox"/> Skin Eruptions	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Eczema	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Asthma
<input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Inability to control Urine	<input type="checkbox"/> Difficulty Breathing

What are your short-term health goals?

What are your long-term health goals?

How would you rate you current level of Wellness? From 0 (Poor) to 10 (Optimal Health and Wellness)

What are your desired outcomes from your care at CHIROSPO RTS?

Consent to Chiropractic Care

At CHIROSPO RTS we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare, random and unpredictable event. Other risks that can be associated with spinal adjustments include disk injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know. I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns they can be discussed with my chiropractor. I appreciate that I will receive the best care possible at CHIROSPO RTS but that results can not be guaranteed.

Patients Signature Date .../.../... Witness

Your information is private and confidential, however we may need to correspond with various third parties, including your GP, specialist or Insurance Company. Limited information may / may not be used as a patient testimonial with / without my name. I, give Chiro sports permission to release my information for this purpose.

Patients Signature Date .../.../... Witness