Patient Questionnaire: Teenager 13-18

General Information

Full Name: _____

Gender: M/F/Non-Binary Date of Birth: _____

Address: _____

_____Post Code: _____

Your Mobile Number: _____ Your Email Address_____

Carer's Name: _____ Carer's Contact number: _____

Carers Email: _____ Carer's Relationship to you: _____

How did you find out about Health Matters? Signage / Internet/ Personal Reference/Social Media
Who can we thank for referring you?_____

Have you been to a Chiropractor before? Yes/No ?
If yes, with who and when was your last adjustment?_____

General Practitioner (Who/Where): _____

Present Health

It may surprise you to know that our Chiropractors do not treat symptoms, instead they aim to find the underlying cause(s) of your pain or condition to help your body to heal. People present at this clinic in various stages of health or wellness. If you are experiencing symptoms, please describe them as fully and informatively as possibly through answering the following questions.

Major symptom/concern: _____

When/how it begun: _____ Has it happened before? YES NO

If YES, when did this last occur? _____

If painful, describe the pain: Sharp ☐ Dull ☐ Burning ☐ Constant ☐ Intermittent ☐ Aching ☐
If the pain affects other parts of your body, please specify: _____

Is the problem getting better? YES NO Does it interfere with: Sleep ☐ School ☐ Routine ☐

What brings the problem on or aggravates it? _____

What relieves it or makes it feel better? _____

If you have tried any other treatments, please specify: _____

Are there any other problems or concerns you would like to address today?

_____

_____

Daily Activities

Our daily activities have a big impact on our overall health and wellbeing as well as affecting out rate of healing. Knowing how you use your body will help your practitioners not only understand what you have the problem but also help them to accurately diagnose, assess and treat them.

Please circle the following things you do on a daily basis:

Sitting	Walking	Heavy Lifting	Writing	Repetitive Tasks
Standing	Manual Labour	Desk work	Driving	Backpack use

Do you play an instrument? YES NO If YES, what kind? _____

Do you read for prolonged periods of time? YES NO How long? _____ hours

What do you read from? BOOK or ELECTRONIC DEVICE

How much time per day do you spend on an electronic device? Approximately _____ hours

Sleeping posture: Side ☐ Back ☐ Stomach ☐ Hourly average per night? _____ hours

Sports you play/used to play: _____ now ☐ in the past ☐
_____ now ☐ in the past ☐
_____ now ☐ in the past ☐
_____ now ☐ in the past ☐

Hobbies and interests: _____

How often do you exercise? Daily ☐ 3-5 times a week ☐ Occasionally ☐ Never ☐

Exercise details: _____

Do you smoke? YES NO How many per day? _____

Do you drink alcohol? YES NO How many per day? _____

Do you drink caffeine? YES NO How many per day? _____

Do you use recreational drugs? YES NO Details: _____

Do you follow a particular diet? YES NO Details: _____

Do you crave any specific foods? YES NO Details: _____

How much water do you drink each day? Details: _____

How would you define your eating habits? Excellent ☐ Good ☐ Moderate ☐ Poor ☐

How stressful is your lifestyle? LOW 1 2 3 4 5 6 7 8 9 10 HIGH

How would you rate your health? POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

Health History

Please tick +/- circle the following symptoms you have experienced in the past 12months:

☐ Neck pain/stiffness	☐ Bowel/bladder problems	☐ Dizziness/ringing in ears
☐ Headaches/migraines	☐ Difficulty sleeping	☐ Hayfever/sinus
☐ Nervousness/depression	☐ Fatigue	☐ Pain between shoulders
☐ Asthma	☐ Chest pain	☐ Numbness in feet/legs
☐ Digestive issues	☐ Recurrent colds/flus	☐ Numbness in hands/arms
☐ Low back pain	☐ Leg pain/cramps	☐ Breathing issues
☐ Constipation/diarrhoea	☐ Infertility	☐ Snoring
☐ Hip pain	☐ Menstrual problems	☐ Jaw pain
☐ Reflux/nausea/vomiting	☐ Arthritis	☐ Grinding/clenching teeth
☐ Concussion	☐ Incontinence	☐ Memory concerns
☐ High/low blood pressure	☐ High blood cholesterol	☐ High/low blood sugar

List ALL other medical conditions you have been diagnosed with: _____

_____

List ALL surgeries or hospitalisations and when they occurred: _____

_____

Are you currently on any medications or supplements? YES NO

Product 1: _____ Product 2: _____

Product 3: _____ Product 4: _____

Product 5: _____ Product 6: _____

List ALL vaccinations received in the last 10 years:_____

_____

Have you fractured any bones? Yes/No Details: _____

Have you had any significant accidents/traumas/falls? Yes/No Details: _____

List all allergies, known or suspected: _____

Do you have a family history of: Cancer ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐
Dementia ☐ Mental Illness ☐ Hypertension ☐

Are you currently under the care of other healthcare professionals? Yes/No

Name: _____ Profession: _____

Name: _____ Profession: _____

Name: _____ Profession: _____

Is there anything else you feel we should know in order to help you achieve maximum health and happiness?

_____

_____

_____

_____

Legal Stuff

Privacy Policy Statement:
In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also, when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Policies on Fees, Guarantees, Disclosed Information and Research:

1. I understand that appointments not attended or cancelled with less than 24hours notice may incur a charge and that payment is required at the time of consultation. This fee is $50 for cancellations with less that 24 hours notice and a full scheduled fee for appointments not cancelled and not attended.
2. I appreciate that positive results of any treatment that I receive at Health Matters is not guaranteed. I understand that the team at Health Matters does not aim to treat my symptoms, but address any dysfunction identified.
3. I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the questionnaire provided, and agree to provide any related new information during the period of care at this clinic, or by practitioners who have assessed or treated me at this clinic.
4. Information gained from the initial assessment and follow up sessions may be used for internal research purposes or publishable research to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details, etc.) will be disclosed in any published material.

Risks of Care and Consent for Care:

5. As with any health care examination and treatment there is a risk of the condition changing. Current (2009) research from the International Chiropractic Pediatric Association demonstrated **chiropractic care is very safe and effective for children**. The research of 5438 chiropractic visits, 577 children, indicated only two children (<1%) experience minor discomfort after adjustments, which readily resolved with continued chiropractic care. The research showed both parents and doctors indicated a high rate of improvement with respect to the children's presenting complaints. Parents also reported better sleeping patterns, improvements in behaviour and, improved immune system function while under chiropractic care.
6. Chiropractic and other techniques used at this clinic are well recognised as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines, there is a risk of complications. This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (current statistics e.g. between 1 in 2million to 1 in 5.85 million – Haldeman, et al. Spine vol 24-8 1999) or side effects caused by the use of nutritional or herbal products that may be recommended. If I have any concerns, I will discuss them prior to treatment or during the course of a treatment programme if any new concerns arise.
7. I understand that the above mentioned risks of treatment exist. However, I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
8. I hereby acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Name: _____

Signature: _____ Date: _____

Carer's Name: _____

Signature: _____ Date: _____