Patient Questionnaire: Adult

General Information

Full Name: _____

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

Address: _____

_____ Post Code: _____

Contact number: _____ Occupation: _____

Email address: _____

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?_____

Present Health

It may surprise you to know that our Practitioners 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 you can by answering the following:

Major symptom/concern: _____

When/how it begun: _____ Has it happened before? Yes/No

If yes, when did it last occur: _____

Does this affect other parts of your body Yes/No Where: _____

Is it getting better Yes/No What brings it on or aggravates it? _____

What relieves it or makes it feel better? _____

Does the problem interfere with: Sleep ☐ Work ☐ Daily Routine ☐_____

Have you tried any other treatments? _____

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

_____

Daily Activities

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

Tick your daily activities: Sitting ☐ Walking ☐ Heavy Lifting ☐ Writing ☐ Standing ☐

Manual Labour ☐ Emotional Stress ☐ Desk Work ☐ Driving ☐ Repetitive Tasks ☐

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

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

_____ now ☐ in the past ☐

_____ now ☐ in the past ☐

Hobbies and interests: _____

Are you trying to: Gain weight ☐ Lose weight ☐ Conceive a child ☐

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

Exercise details: _____

Do you smoke? Yes/No/Ex 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/Ex Details: _____

Do you follow a particular diet? Yes/No Details: _____

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

Do you crave any specific foods? _____

How much water do you drink on an average day? _____

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

Please tick any of the following feelings/emotions you experience more than once a week:

Frustration ☐ Depressed ☐ Anxious ☐ Resentful ☐ Negativity ☐ Anger ☐

Loneliness ☐ Sadness ☐ Cynical ☐ Unloved ☐ Self doubt ☐

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

Have you ever been diagnosed with any of the following? If YES, please indicate when:

Cancer ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ Depression ☐ Anaphylaxis ☐

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

List ALL surgeries or hospitalisations and when they occurred: _____

List ALL medications and supplements you take regularly: _____

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 ☐

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 24hours 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. 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.

6. 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.

7. 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: _____