Lamp Chiropractic

Patient Information

First Name(s)..... Last Name.....

Address: ..... Suburb ..... Post Code .....

Date of Birth: / / Age: ..... Gender (circle): M / F

Occupation: .....

Mobile: ..... Home: .....

Email: .....

Marital Status (circle): ▪Single ▪Defacto ▪Married ▪Divorced

No. of children and Ages?.....

In case of emergency please contact:

Name: ..... Relationship: .....

Telephone: Home: ..... Mobile: .....

How did you hear about the Clinic?.....

Patient Condition

What is your major complaint? .....

When did your symptoms begin? .....

Is your condition (circle)? ▪Getting Worse ▪Remaining Constant
▪Coming/Going ▪Getting Better

What makes this condition better?.....

What makes this condition worse? .....

Have you ever experienced this before? Y / N If yes: When?

.....

Have you ever had previous Chiropractic care? Y / N If yes:
When and by whom?

.....

PTO

Patient History

Please place a tick next to the symptoms you currently have or have experienced recently - it is important in helping us gain an understanding of your general health:

□Dizziness	□Convulsions/tremors	□Coughing up mucous	□Voice change
□Fainting	□Chills	□Coughing up blood	□Frequent urination
□Double vision	□Fever	□Asthma/wheezing	□Painful urination
□Difficulty speaking	□Fatigue	□Rashes	□Blood in urine
□Difficulty swallowing	□Headache	□Easy bruising	□Incontinence
□Difficulty walking	□Loss of sleep	□Hives	□Kidney stones
□Nausea	□Loss of weight	□Loss of hair	□Bed wetting
□Numbness	□Sweats	□Colds/flu	□Prostate problems
□Constipation	□Recent infection	□Deafness	□Hormone problem
□Diarrhea	□Pain over heart	□Ringing in ears	□Thyroid disease
□Hemorrhoid	□Angina pectoris	□Earache	□Diabetes
□Poor appetite	□Palpitations	□Enlarged glands	□Heat/cold intolerance
□Vomiting blood	□High blood pressure	□Failing vision	□Excessive thirst
□Jaundice	□Shortness of breath	□Nose bleeds	□Anemia
□Abdominal Pain	□Swelling of ankles	□Sinus infection	□Blood transfusion
□Heartburn	□Frequent coughing	□Ulcers	□Allergies

Other:……

Please list and provide dates for any hospitalisations/surgeries/accidents/major injuries you have previously had:

……

Please list any medication including; vitamins/herbal supplements/prescription medication/over-the-counter medications you are taking:

……

In the last year have you had any of the following (circle):

▪X-ray ▪CT scan ▪MRI ▪Blood test

If so, describe the reason

……

Family History

Is there a history of any of the following in your family (circle)?

		Relationship to you			Relationship to you
Cancer	Y/N	_____	Arthritis	Y/N	_____
High Blood Pressure	Y/N	_____	Migraine	Y/N	_____
Heart Attack	Y/N	_____	Diabetes	Y/N	_____
Stroke	Y/N	_____	Psychological Disorder	Y/N	_____
Other:					

……

Psychosocial History

Do you drink coffee?	Y/N	____ /day	Do you drink alcohol?	Y/N	___ /day/week
Do you smoke?	Y/N	____ /day	Are you an ex-smoker?	Y/N	

Have any of the following recently occurred?

Divorce/Relationship Break-up	Y/N	Family Problems	Y/N
Depression	Y/N	Sleep Disturbances	Y/N
A death	Y/N	Work Problems	Y/N
Increased Anxiety Level	Y/N	Moved house	Y/N

Does your current work involve (circle):

Heavy Work Lifting/Carrying Vibration Monotonous Movements
Other:

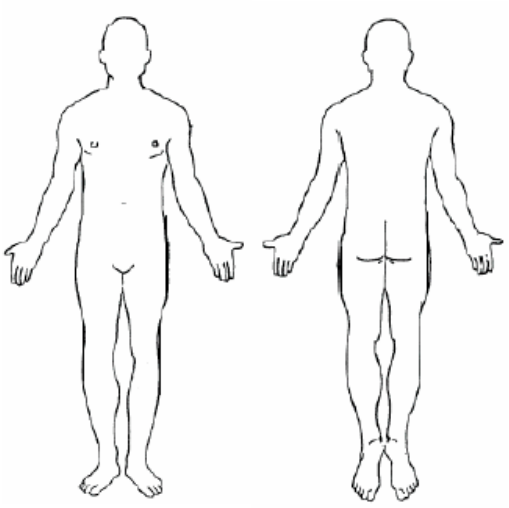
.....

What sports/recreational activities do you preform on a regular basis?

.....

Please use the diagram below to indicate the symptoms you have been experiencing over the past 24hrs. Use the key to indicate the type of symptoms.

Key: Pins/Needles = 0000000 Stabbing = ////////////
Burning = XXXXXX Aching = VVVVVVV



Please mark the following line to indicate the level of your CURRENT pain:

_____

No Pain Worst Pain Imaginable

<u>Consent to Chiropractic Care</u>

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully:

- I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include, although are not limited to, muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation or my underlying condition.
- I have had the opportunity to discuss the proposed care with my chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
- I acknowledge that I am aware of and understand the potential risks, I appreciate that results are not guaranteed.
- I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- I hereby acknowledge my consent to the performance of the proposed chiropractic care by my chiropractor and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

_____ Date: _____
Patient's Signature
(*Parent or Guardian to also sign if patient is under 18)*

Please hand form to Reception, Thank you

Doctors Use Only

Obs/Post

Palp

BP

Pulse

Height

Weight

Reflex

Bi-c6
Pat-l5

Tri-c7
Ach-s1

B/R-c6
Bab

Cervical	Thoracic	Lumbar	ROM C T L
Maignes	Rib Compression	SLR	
Compression Tests	Adam's Test	Slump	
- Flexion	Passive Scap. Approx	Valsalva's	
- Extension	Sternal Compression	Kemp's	
- Lat. Flexion		Gaenslen's	
- Maximal		Yeoman's'	
Cervical Distraction		Pelvic Compression	
Soto-Hall		Sign of the Butt.	
Other:			

Special Tests/Other Tests/Regional Exams

Listings C T L SI

Stretch C: Rom : Rotation T: Rhomboid - Seated/Standing: Pec L: knee/chest : piriformis – sup/seated OTHER

Advice

XRAY Y / N

Additional Notes

YELL FLAGS

RED FLAGS

TREATMENT PLAN