CATALYST CHIROPRACTIC

Catalyst Health and Wellness Group

604 Barkly Street, Ballarat, VIC 3350

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date: _____

Surname:	First Name:	Preferred Name:
Address:	Town:	
Medicare No:	Post Code:	
Home Ph:	Work Ph:	Mobile Ph:
Birth Date: / /	Email:	
Occupation:	Employed by:	
Type of work: ☐ Sitting ☐ Computer ☐ Standing ☐ Driving ☐ Lifting ☐ Other_____		
Spouse's name:	Do you have a concession? ☐ Yes ☐ No ☐ Number:	
Children's name & ages:		
Do you have private health insurance that covers you for chiropractic care? Yes / No If yes, which fund: _____		
Referred By: ❑ Family or Friend – Name: _____ ❑ Signage ❑ Google ❑ Facebook		

Please <u>list</u> your chief complaints in order of severity;
Or <u>tick here</u> if your reason for attending is to improve Health & Wellness ☐

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the MAIN problem? _____
Is the pain ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Like pins & needles
Does the pain spread? ☐ Yes ☐ No If yes, to where?
Do you have numbness? ☐ Yes ☐ No If yes, where?
Is there pain when you cough or sneeze? ☐ Yes ☐ No If yes, where?
Is there pain when you sit or stand? ☐ Yes ☐ No If yes, where?
Is the pain getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes
Do you have headaches? ☐ Yes ☐ No If yes, circle all that apply:
Tension Throbbing Sinus Migraine Other:_____

Indicate any function below that aggravates or is aggravated by your condition *(please circle all that apply):*
Walking Steep climbing Driving Working Recreation Bowel movements Digestion
Vision Breathing Sinuses Hearing Smelling Sleeping If female, menstruation

Does you father, mother, sister, brother or children have similar problems? ☐ Yes ☐ No If yes, who? _____

Previous chiropractic care *(leave blank if no previous chiropractic care)*
Previous chiropractor's name:_____ Approximate date of last visit: _____
Type of care: Symptom based / Non-symptom based *(wellness or maintenance)*
Duration of care: Days / Weeks / Months / Years
Techniques used: _____ / Not sure
Were you happy with care? Yes / No Why / why not? _____

Imaging History			
☐ Previous x-rays	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous MRIs	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous CT scans	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Other imaging	Approx. Date: ___/___/___	Area:	Do you have a copy of report?

Please list any operations you have had:

1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had:

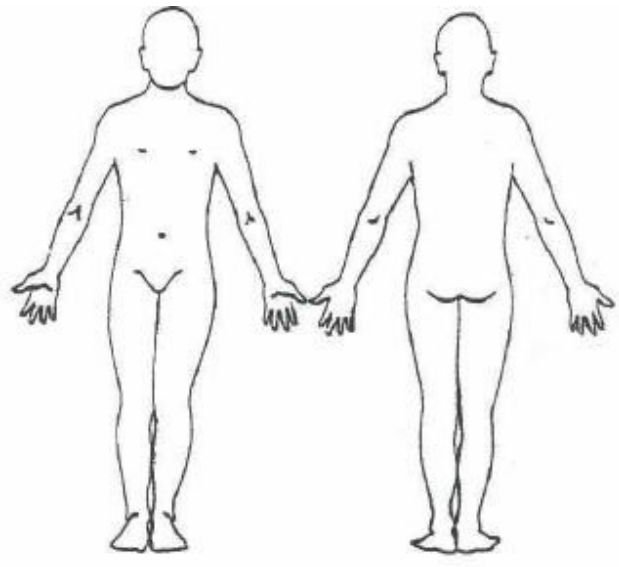
1. _____ 2. _____ 3. _____

General Practitioner's Details	
Name:	Clinic name:

Is there any chance that you are pregnant? ☐ Yes ☐ No If Yes, how many weeks pregnant? _____ weeks

Please mark areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
_____	OOOOOOOOO	XXXXXX	********	//////////////



Pain Chart:

Neck/Shoulder/Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Physical Stress

Have you experienced any **physical traumas**, such as car accidents, sporting accidents, falls etc *(Please include seemingly insignificant traumas)* at any stage of your life – even as a child?

☐ Yes ☐ No _____

_____

_____

_____

What **exercise** do you currently do and how often do you do it? _____

List any ALLERGIES: _____

List any MEDICATIONS (include prescription, non-script) or Supplements that you take: _____

_____

Please indicate if you have **EVER** had, currently or in the past, any problems in the following areas:

Current/Past	Current/Past	Current/Past
❑❑ Eyes/Vision (Blurring etc)	❑❑ Bladder control / Infections	❑❑ Growing Pains
❑❑ See spots / lights / halos	❑❑ Bowels	❑❑ Balance / Coordination
❑❑ Ears / Hearing / Ringing in ears	❑❑ Constipation / Diarrhoea	❑❑ Attention / Concentration
❑❑ Nose / Jaw / Throat	❑❑ Blood Pressure High / Low	❑❑ Speech / Taste
❑❑ Neck	❑❑ Reproductive organs	❑❑ Nausea / Vomiting
❑❑ Shoulders / Upper Arm	❑❑ Nervous System	❑❑ Forgetfulness
❑❑ Elbows / Forearms	❑❑ Headaches / Migraines	❑❑ Mood Changes
❑❑ Wrists / Hands	❑❑ Allergies / Hay Fever	❑❑ Fatigue / Exhaustion
❑❑ Upper Back	❑❑ Dizziness	❑❑ Anxiety / Depression
❑❑ Lower Back	❑❑ Diabetes / Pancreas	❑❑ Cramps
❑❑ Pelvis / Hips / Coccyx	❑❑ Thyroid	❑❑ Jumpy legs at night
❑❑ Groin / Thighs	❑❑ Indigestion / Reflux	❑❑ Motion Sickness
❑❑ Calves / Lower Legs	❑❑ Hearth / Circulation	❑❑ Unexplained bleeding
❑❑ Knees / Ankles / Feet	❑❑ Kidneys	❑❑ Loss of appetite
❑❑ Chest / Lungs / Asthma	❑❑ Inflammatory Arthritis	❑❑ Weight loss / gain
❑❑ Low Energy	❑❑ Knocked Unconscious	❑❑ Fainting / Blackouts

Legs and Feet

1. Do you experience pain in your legs or feet? Yes ❑ No ❑
2. Do you think you have mechanical foot problems? Yes ❑ No ❑

FAMILY HISTORY - Have any of your family members suffered from:

Heart Disease **Yes / No, who? _____**
Cancer **Yes / No, who? _____**
Stroke **Yes / No, who? _____**
Inflammatory Arthritis **Yes / No, who? _____**