Salus Chiropractic Clinic

Date:

INITIAL CONSULTATION FORM

Confidential

PATIENT INFORMATION

Patient's Given name: Middle: Surname:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar/ Defacto / Div / Sep / Wid
Country of Birth:	D.O.B: / /		Age:	Male: ❑ Female: ❑
Street address:		Suburb:		Post Code:
State:	Phone (H): ( )	Phone (W) ( )		Mobile Number:
Occupation:	Email Address:			Do you wish to be sent reminders for you appointments? ❑ Yes (Via SMS/Email) ❑ No

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Health Insurance Provider	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other:

Other family members seen here:

PRESENTING COMPLAINT

Please describe your present problem:

When did this problem start?

What were you doing?

What makes it better?	What makes it worse?

Describe the feeling or sensation you have with this problem (Please tick/circle)

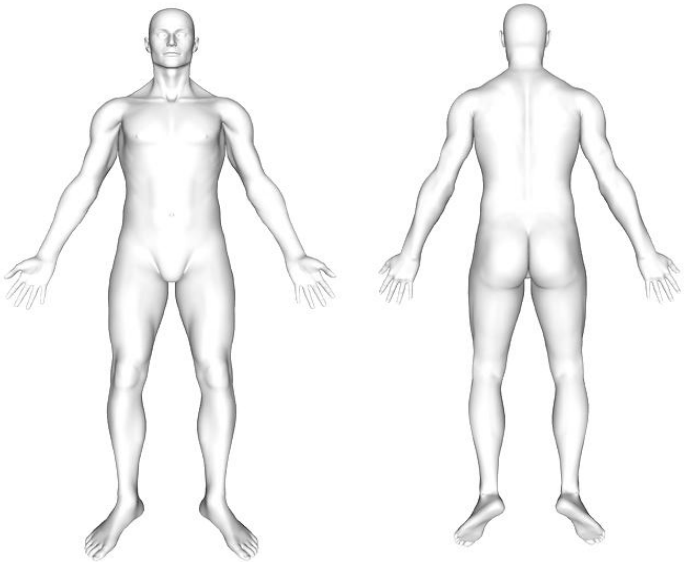
❑ Health Check (No Problems)	❑ Sharp Pain	❑ Dull Pain	❑ Ache	❑ Weakness	❑ Throbbing
	❑ Numb	❑ Shooting	❑ Gripping	❑ Burning	❑ Tingling (Pins & Needles)

Please mark on the diagram where you have pain and/or other symptoms:

Please use symbols to indicate sensation:
(x) for pain
(0) for numbness/pins & needles

Are your symptoms:
❑ Increasing
❑ Decreasing
❑ Not changing

How frequent is the pain:
❑ Constant
❑ Intermittent
❑ Occasional
❑ Rarely



Note:

Please include any other associated symptoms which you would like to indicate

Other spinal problems:

Other peripheral problems:

VAS: On a scale of zero (0) to ten (10) how you rate your current pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

My symptoms are affecting (please tick / circle): ❑ General Activities ❑ Leisure ❑ Sleep ❑ Work ❑ Other (please describe) :

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1 Dragon Street HILLCREST SA 5086

MEDICAL & FAMILY INFORMATION

(If unsure or not known please leave blank)

Previous Chiropractor / Acupuncturist:	Date of last visit:
Current Medical Practitioner (GP) :	Practice / Clinic:
Hospitalisation &/or Surgeries:	
Accidents & Trauma:	

Current Medications & Supplements:	Family History:	
	❑ Cancer ❑ High Blood Pressure ❑ Diabetes ❑ Arthritis	❑ Stroke ❑ Heart Attack ❑ Seizures/Convulsions ❑ Mental Illness
Do you smoke: ❑ No ❑ Yes How much:	Do you drink alcohol: ❑ No ❑ Yes How much:	

What are your stress levels like (1 minimal, 10 major/burnout): Work ( ) Home Life ( ) Financial ( ) Health ( ) Other ( )

SYSTEMS REVIEW

Do you now, or have ever had, any of the following (please tick)

General / Constitutional
- ❑ Unexplained weight loss
- ❑ Excessive fatigue
- ❑ Prolonged fever / chills
- ❑ night sweats
- ❑ do you have trouble sleeping
- ❑ allergies
- ❑ other

Head / Eyes / Ears / Nose / Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Wear glasses or contact lens
- ❑ Chronic nasal discharge / sneezing
- ❑ Impaired hearing
- ❑ Recent eye examination
- ❑ other

Gastrointestinal
- ❑ abdominal pain
- ❑ Vomiting
- ❑ loss of appetite
- ❑ change of bowel habits
- ❑ blood in the stools
- ❑ haemorrhoids or rectal disease
- ❑ other

Respiratory
- ❑ chronic cough
- ❑ Asthma or wheezing
- ❑ shortness of breath
- ❑ shortness of breath at night
- ❑ other

Cardiovascular
- ❑ Any heart trouble
- ❑ Pain or pressure in chest / Angina
- ❑ Rheumatic Fever
- ❑ Palpitation or pounding heart
- ❑ Swelling of ankles
- ❑ High blood pressure
- ❑ other

Haematological / Lymph
- ❑ anaemia
- ❑ excessive bleeding / bruising
- ❑ a transfusion
- ❑ any swelling of lymph glands
- ❑ other

Neurological
- ❑ Memory loss
- ❑ fainting, dizziness, convulsions
- ❑ slurred speech
- ❑ other

Skin / Breast
- ❑ change or new growth in mole
- ❑ breast lump
- ❑ breast nipple discharge
- ❑ other

Genitourinary
- ❑ frequent urination at night
- ❑ frequent or painful urination
- ❑ difficulty holding urine
- ❑ difficulty stopping / starting urine flow
- ❑ urinary tract infection
- ❑ other

Endocrine
- ❑ cold or heat intolerance
- ❑ excessive thirst or hunger
- ❑ trouble losing weight
- ❑ other

Musculoskeletal
- ❑ pain in the joints / arthritis
- ❑ red inflamed joints
- ❑ chronic back pain or injury
- ❑ other

Female
- ❑ mid-cycle bleeding
- ❑ unusual vaginal discharge
- ❑ painful periods
- ❑ inconsistent menstrual cycles
- ❑ premenstrual pain
- ❑ pain with intercourse
- ❑ have you ever been pregnant
- ❑ other

Male
- ❑ sore or discharge from penis
- ❑ lump or pain on testicle
- ❑ problems with sexual function
- ❑ other

Psychological / Emotional
- ❑ high stress levels
- ❑ are you often depressed
- ❑ are you often anxious or nervous
- ❑ ever had loss of memory
- ❑ other

Signed: **Date:**

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