

CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (DD/MM/YYYY) _____

Have you consulted a chiropractor before?

No Yes **When?** _____

Whom may we thank for referring you? _____

If so, whom? _____

Gender

Male Female

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

Birth Date (DD/MM/YYYY) _____

Marital Status

Single Married Divorced
 Widowed Separated

Address _____

City _____

State _____

Post Code _____

Home Phone _____

Spouse's Name _____

Email Address _____

Mobile Phone _____

Child's Name and Age _____

Emergency Contact _____

Phone _____

Child's Name and Age _____

Your Occupation _____

Child's Name and Age _____

Your Employer _____

Work Phone _____

May we contact you at work?

Yes No

Name of GP _____

Insurance Details if Necessary _____

WorkCover / Motor Accident / DVA / Other _____

Claim Number _____

Name of Case Manager _____

Case Manager's Phone Number _____

I acknowledge that health information is required to be collected by the Murray Valley Chiropractic Centre in order to provide effective and appropriate treatment. I consent to and authorise the collection of such information and agree that the medical information recorded may be retained by the Murray Valley Chiropractic Centre for the purpose of future treatment. I am also aware of the consultation fees and understand fees are to be paid at the time of consultation.

Signature _____

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle):

- An accident or injury
 - Work Auto Other _____
- A worsening long-term problem
- An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity (How extreme are your current symptoms?)

0 10

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

Constant Come and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

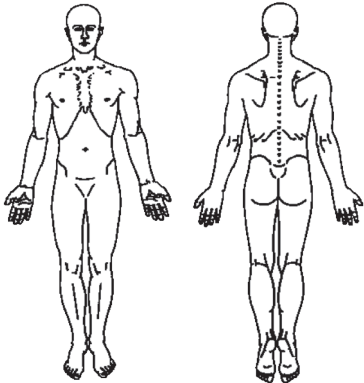
Numbness Stiffness Aching Nagging Burning Throbbing

Tingling Dull Cramps Sharp Shooting Stabbing

Other _____

7. Location (Where does it hurt?)

Circle the area (s) on the illustration.



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

Prescription medication Surgery Other _____

Over-the-counter drugs Acupuncture _____

Homeopathic remedies Chiropractic _____

Physical therapy Massage _____

11. What else should the Murray Valley Chiropractic Centre know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

Consultation Notes

Doctor's Initials _____

Murray Valley
Chiropractic
Centre

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | |

d. Respiratory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | |

g. Integumentary

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | |

h. Endocrine

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Thyroid issues | <input type="radio"/> Immune disorders | <input type="radio"/> Hypoglycemia | <input type="radio"/> Frequent infection | <input type="radio"/> Swollen glands | <input type="radio"/> Low energy | |

i. Genitourinary

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Kidney stones | <input type="radio"/> Infertility | <input type="radio"/> Bedwetting | <input type="radio"/> Prostate issues | <input type="radio"/> Erectile dysfunction | <input type="radio"/> PMS symptoms | |

j. Constitutional

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Fainting | <input type="radio"/> Low libido | <input type="radio"/> Poor appetite | <input type="radio"/> Fatigue | <input type="radio"/> Sudden weight change | <input type="radio"/> Weakness | |

Patient name

All other systems negative

Consultation Notes

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

<div data-bbox="66 1125 511 1902"> <h4>14. Illnesses</h4> <p>Check the illnesses you have Had in the past or Have now.</p> <table border="0"> <tr> <td>Had <input type="radio"/></td> <td>Have <input type="radio"/></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Allergies</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Arteriosclerosis</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Cancer</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Chicken pox</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Epilepsy</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Glaucoma</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Goiter</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Gout</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Heart disease</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Hepatitis</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Multiple Sclerosis</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Polio</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Rheumatic fever</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Spine: _____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>_____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Stroke/TIA</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Tuberculosis</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Ulcer</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other: _____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>_____</td> </tr> </table> </div>	Had <input type="radio"/>	Have <input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	Arteriosclerosis	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Chicken pox	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Goiter	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Heart disease	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	Polio	<input type="radio"/>	<input type="radio"/>	Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Spine: _____	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>	Stroke/TIA	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>	Other: _____	<input type="radio"/>	<input type="radio"/>	_____	<div data-bbox="511 1125 893 1902"> <h4>15. Operations</h4> <p>Surgical interventions, which may or may not have included hospitalization.</p> <ul style="list-style-type: none"> <input type="radio"/> Appendix removal <input type="radio"/> Bypass surgery <input type="radio"/> Cancer <input type="radio"/> Cosmetic surgery <input type="radio"/> Elective surgery: _____ _____ <input type="radio"/> Eye surgery <input type="radio"/> Hysterectomy <input type="radio"/> Pacemaker <input type="radio"/> Tonsillectomy <input type="radio"/> Vasectomy <input type="radio"/> Other: _____ _____ _____ <h4>17. Injuries</h4> <p>Have you ever...</p> <ul style="list-style-type: none"> <input type="radio"/> Had a fractured or broken bone <input type="radio"/> Had a spine or nerve disorder <input type="radio"/> Been knocked unconscious <input type="radio"/> Been injured in an accident <input type="radio"/> Used a crutch or other support <input type="radio"/> Used neck or back bracing <input type="radio"/> Received a tattoo <input type="radio"/> Had a body piercing </div>	<div data-bbox="893 1125 1299 1902"> <h4>16. Treatments</h4> <p>Check the ones you've received in the Past or are receiving Currently.</p> <table border="0"> <tr> <td>Past <input type="radio"/></td> <td>Currently <input type="radio"/></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Acupuncture</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Antibiotics</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Birth control pills</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Blood transfusions</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Chemotherapy</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Chiropractic care</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Dialysis</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Herbs</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Homeopathy</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Hormone replacement</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Inhaler</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Massage therapy</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Physical therapy</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Nutritional supplements: _____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>_____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Medications (prescription and over-the-counter): _____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>_____</td> </tr> </table> </div>	Past <input type="radio"/>	Currently <input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Acupuncture	<input type="radio"/>	<input type="radio"/>	Antibiotics	<input type="radio"/>	<input type="radio"/>	Birth control pills	<input type="radio"/>	<input type="radio"/>	Blood transfusions	<input type="radio"/>	<input type="radio"/>	Chemotherapy	<input type="radio"/>	<input type="radio"/>	Chiropractic care	<input type="radio"/>	<input type="radio"/>	Dialysis	<input type="radio"/>	<input type="radio"/>	Herbs	<input type="radio"/>	<input type="radio"/>	Homeopathy	<input type="radio"/>	<input type="radio"/>	Hormone replacement	<input type="radio"/>	<input type="radio"/>	Inhaler	<input type="radio"/>	<input type="radio"/>	Massage therapy	<input type="radio"/>	<input type="radio"/>	Physical therapy	<input type="radio"/>	<input type="radio"/>	Nutritional supplements: _____	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>	Medications (prescription and over-the-counter): _____	<input type="radio"/>	<input type="radio"/>	_____
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PERSONAL

Doctor's Initials

Murray Valley
Chiropractic
Centre

18. Family History

Some health issues are hereditary. Tell the Murray Valley Chiropractic Centre about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

Patient name _____

19. Are there any other hereditary health issues that you know about?

20. Social History

Tell the Murray Valley Chiropractic Centre about your health habits and stress levels.

SOCIAL	Alcohol use			Pain relievers		
	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____
	Coffee use <input type="radio"/> Daily <input type="radio"/> Weekly How much? _____			Soft drinks <input type="radio"/> Daily <input type="radio"/> Weekly How much? _____		
	Tobacco use <input type="radio"/> Daily <input type="radio"/> Weekly How much? _____			Water intake <input type="radio"/> Daily <input type="radio"/> Weekly How much? _____		
	Exercising <input type="radio"/> Daily <input type="radio"/> Weekly How much? _____			Hobbies: _____		

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Consultation Notes

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

If the patient is a minor child, print child's full name: _____

Doctor's Initials _____

**Murray Valley
Chiropractic
Centre**

Signature _____

Date (DD/MM/YYYY) _____