Doctor's Examination Notes

Date: _____

Doctor: _____

Number: _____

belridge chiropractic

DATE: _____
DR: _____
NUMBER: _____

Full Name (Mr/Ms/Mrs) _____ Date of Birth _____

Address _____

Phone (Mob)_____ (H) _____ (W) _____

Email _____

Occupation _____ Number of Children _____

How did you hear about us? _____

Concession Card _____ Expiry Date _____

Medical Doctor _____ Emergency Contact _____

Have you had chiropractic before? (Yes/No) Where? _____

What is the reason for your visit today? _____

If coming for an existing injury/pain, what caused it and when? _____

_____

What makes it worse? _____

What makes it better? _____

What aspect of your life does this stop you enjoying? _____

_____

What other treatment have you had? _____

Have you had spinal x-rays taken in the last two years? (Yes/No) Where? _____

Any hospitalisations/surgeries ever (date/reason) _____

_____

Have you had a car accident or a major trauma? _____

Have you suffered any broken bones or dislocations? _____

Are you Pregnant? (Yes/No) Date of last period _____

What else should we know about you? _____

Current Medications/Supplements

Please disclose all including OVER THE COUNTER, Prescriptions Medications and Supplements.

BRAND	PRODUCT NAME	PRESCRIBED BY	DOSE ml/tab	X DAY

Current Health

Do you ever have any of the following?

- ○ Allergies
- ○ Arthritis
- ○ Anxiety
- ○ Asthma
- ○ Bladder Condition
- ○ Blurred Vision
- ○ Constipation (stools <1x day)
- ○ Diarrhoea
- ○ Dizziness
- ○ Diabetes
- ○ Difficulty Walking
- ○ Depression
- ○ Fainting
- ○ Fatigue/Poor Energy
- ○ Hayfever/Sinus
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Heart Condition
- ○ Hot Flushes
- ○ Indigestion/Reflux
- ○ Joint Conditions
- ○ Ligament Conditions
- ○ Menstrual Pain/PMS/PCOS
- ○ Mood Swings
- ○ Menopause
- ○ Skin Condition
- ○ Speech Condition
- ○ Swallowing Difficulties
- ○ Thyroid Condition
- ○ Ulcer/s
- ○ Strange Eye Movements
- ○ Sleep Disturbances
- ○ Headaches/Migraines

What is your stress level (0= none, 10= max) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

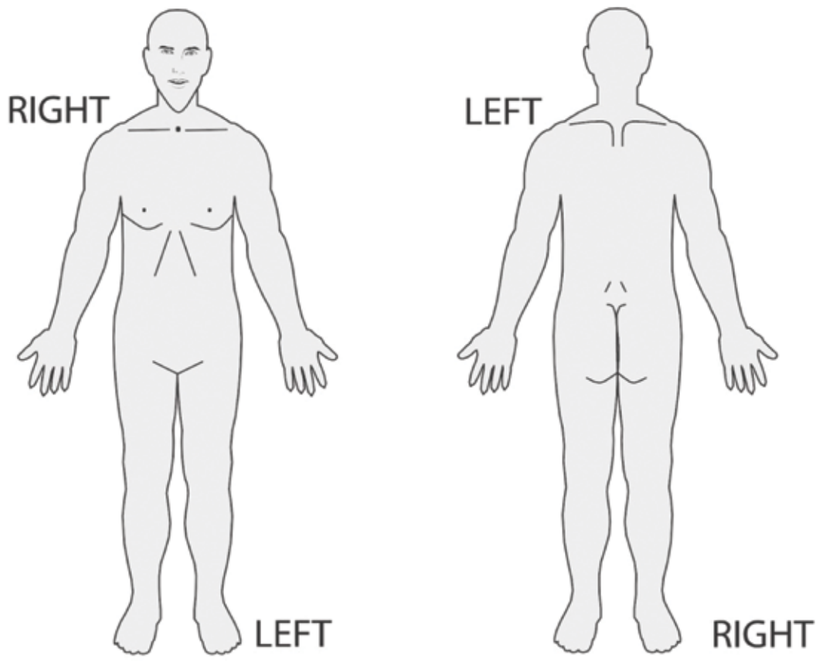
What is your energy level (0= none, 10= max) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Do you suffer from cramps? (Yes/No)

Do you suffer from numbness? (Yes/No)

Do you suffer from pins and needles? (Yes/No)

Please mark any areas of discomfort and pain on the diagram.



Exercise

How often have you exercised this month? _____

What type of exercise? _____

Do you use a trigger point ball or a roller? _____

Hydration & Fluids

I drink _____cups of water per day.

I drink _____carbonated drinks per day.

I drink _____cups of coffee/tea per day.

Context of Care

How long do you think it will take to get your health to where you are happy with it?

_____

Are you interested in discussing your health with our naturopath? (Yes/No)

When was the last time you refreshed your pillow? _____

The information supplied here today is correct to the best of my knowledge. I understand it is my responsibility to inform my chiropractor of any changes in my condition or medication. I understand that payment of my account is required at the time of visit and I am responsible for the cost of my care.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Consent for chiropractic care

Chiropractic has been shown to be an extremely safe and effective treatment for back pain, neck pain, headaches and other similar symptoms.

The risk of injury or complication from chiropractic care is lower than those associated with many other treatments, medications, and procedures given for the same symptoms.

The purpose of this document is to provide you with the information necessary to consent to chiropractic care, including spinal manipulation.

Possible adverse outcomes following care:

- Temporary soreness and tenderness (sometimes)
- Fatigue, headache, dizziness or nausea (uncommon)
- Strain/sprain or disc injury in the neck or lower back (rare)
- Rib fracture (very rare)
- Arterial dissection (extremely rare)

Please note this is not an exhaustive list of all possible outcomes, if you have any specific concerns please raise these with your chiropractor.

On this visit the Chiropractor will have discussed the risks associated with chiropractic care and if you feel that you understand the risk involved, and would like to commence chiropractic care, please sign and date below.

SIGNATURE _____ DATE _____