Dr Ron Sim CHIROPRACTOR

Personal Details

CONFIDENTIAL

NAME: Dr/Mr/Mrs/Ms ……...

ADDRESS: …….

……. POSTCODE: ……..

PHONE HOME: ……... PHONE WORK: …….

MOBILE PHONE: …… EMAIL: …….

BIRTHDATE: ……... OCCUPATION: ……..

MARITAL STATUS: ……... PARTNERS NAME: …….

CHILDREN: ……

RETIRED: ……... TYPE OF WORK (light, heavy): ……..

Is this related to an Accident Compensation [ ] or Third Party Claim [ ] ? [ ] No

Who is your regular doctor (General Practitioner)? …….

We are grateful that our practice grows by referral. Who may we thank for referring you? …….

Have you ever seen a Chiropractor before?

Yes [ ]

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating the function of your spine and system nervous.

Major Complaint

What is your main problem? ……..

……..

When and how did it start? ……..

Was there any of the following prior to or during the onset? (Please circle)

- Illness / infection
- Trauma (Accident)
- Other significant event

Is your problem getting worse? Yes / No ……..

What relieves your symptoms? ……

What makes your symptoms worse? ……

……..

Are your symptoms worse at night or any specific time of the day? ……...

……

Do you have any pain traveling down your arms or legs? Yes / No If yes, describe ……

……..

Does your current problem involve any of the following? If Yes, where?

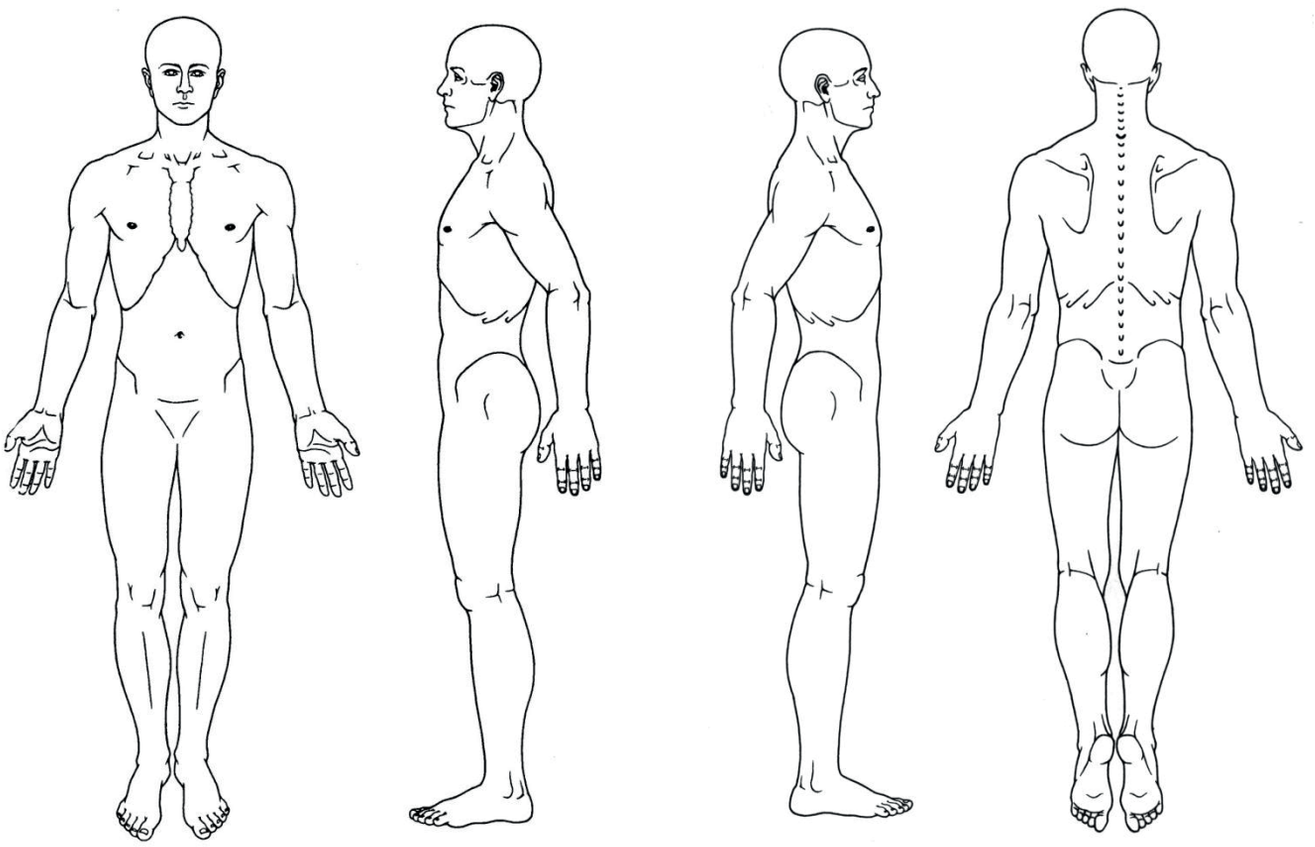
Tingling in either arm or leg	Yes / No	……..
Numbness in either arm or leg	Yes / No	……..
Weakness in either arm or leg	Yes / No	……..
'Weird' sensations in either arm or leg	Yes / No	……..

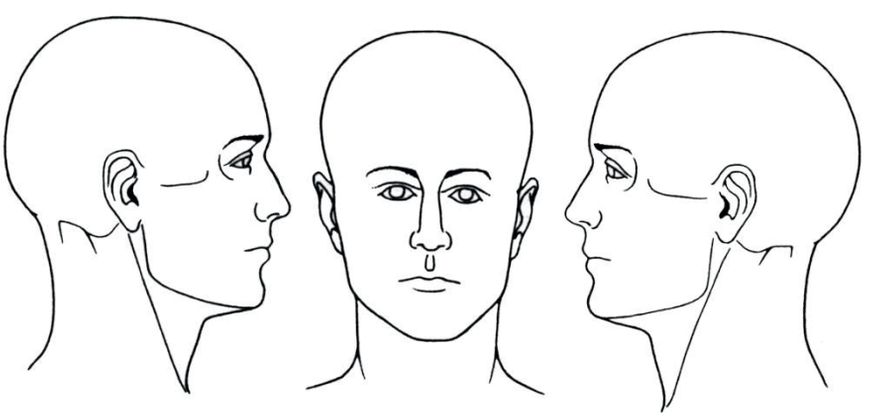
Have you had any other treatment for your current problem? Yes / No ……

……..

Where is the Problem?

Please mark on the diagrams below any areas of discomfort or concern.





Medical History & General Health

Please circle Yes/No where applicable:

Did you / Do you smoke? Yes / No ……..

Did you / Do you drink alcohol? Yes / No ……..

Did / Do you take recreational drugs? Yes / No ……..

Do you think you have a healthy diet? Yes / No ……..

Do you take vitamin supplements? Yes / No ……..

Do you exercise regularly? Yes / No ……..

Have you had any form of surgery? Yes / No ……..

Are you currently taking *any* form of medication? Yes / No If yes list all of them …….

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No ……...

Have you had any broken bones? Yes / No If yes, which ones and how? ……..

Have you had any car accidents (no matter how trivial)? Yes / No If yes, when and describe ……

Have you had any falls or sports injuries? Yes / No If yes, when and describe ……

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No …….

Do you have allergy problems? Yes / No ……..

Do you have poor sleep? Yes / No ……..

Do you suffer from fatigue? Yes / No ……..

Did you / Do you have occupational stress? Yes / No ……..

Do you get pain in any of your joints? Yes / No ……..

If yes, is it worse in the night? Yes / No ……..

Do your joints ever swell?	Yes / No	……..
Do you wake up with stiffness or aching in your joints or muscles?	Yes / No	……..
Are you troubled by waking in the early hours and being unable to sleep again?	Yes / No	……..
Are you often troubled by headaches?	Yes / No	……..
If yes: Are they throbbing and accompanied by sickness?	Yes / No	……..
Are you troubled with pain or aching in your stomach?	Yes / No	……..
If yes: Is it relieved by eating or by drinking milk?	Yes / No	……..
Have you had any persistent change in your appetite during the last three months?	Yes / No	……..
Has your weight changed more than ten pounds (4 Kg) in the last year?	Yes / No	……..
Are you troubled with frequent loose bowel movements?	Yes / No	……..
Are you troubled with constipation?	Yes / No	……..
Have you noticed any blood or mucus in your bowel movements?	Yes / No	……..
Are you troubled with hemorrhoids?	Yes / No	……..
Do you suffer with shortness of breath on exertion?	Yes / No	……..
Are you troubled by pain or tightness in your chest on exertion?	Yes / No	……..
If yes: Is it relieved by resting?	Yes / No	……..
Do you suffer with a cramp-like pain in either leg when walking?	Yes / No	……..
If yes: Do you have to stop or slow down to relieve it?	Yes / No	……..
Do you get cold hands or feet?	Yes / No	……..
Do you have varicose veins?	Yes / No	……..
Does your heart ever seem to miss a beat?	Yes / No	……..
Are you troubled with a frequent or persistent cough?	Yes / No	……..

Do you have any pain or difficulty on passing water?	Yes / No	……..
Are you passing water more frequently lately?	Yes / No	……..
Have you any lumps, cysts, or unusual swellings anywhere on your body?	Yes / No	……..
Are you easily depressed?	Yes / No	……..
Does stress seem to make your main problem worse?	Yes / No	……..
Do you have difficulty concentrating?	Yes / No	……..
Are you subject to blackout, dizzy spells, or faints?	Yes / No	……..
Do you get car/motion sickness?	Yes / No	……..
Do you have poor balance?	Yes / No	……..

EXAMINATION BY THE CHIROPRACTOR

VISUAL Problems .....

POSTURE .....

MUSCLE TONE .....

PALPATION FINDINGS

Cervical ..... Thoracics ..... Lumbars .....

Sacro-iliacs ..... Shoulders ..... Extremities .....

Hands ..... Elbows ..... Feet ..... Knees .....

Muscle tone of extremities ..... Muscle tests .....

Cardiovascular Blood Pressure ..... Heart .....

Bilateral same or different .....

Rate ..... Auscultation .....

Reflexes ..... Upper extremities .....

Lower Extremities ..... Lower extremities .....

X-ray Reports/findings .....

Atypical .....

.....

.....

Osseous ..... Discopathies .....

Facets/Joints ..... Atypical findings .....

ORTHOPAEDIC/NEUROLOGICAL

Standing Trendelenberg Test …… Lewin test …… Kemp sign ……

Supine position Lasegue Test (Straight leg raise) …… Braggard Test (Dorsiflex foot) ……

Patrick-Fabere Test (Sign of 4) ……

Toe in Toe out test (ilio-femoral joint test) …… Hoover sign (Elevate one leg check pressure on opposite) ……

Leg lowering or leg drop test …… pain an indicate positive for disc damage …… Babinski (stroke foot sole) ……

Does toes fan and the great toe dorsiflex ……

Ankle clonus (rapid dorsiflex foot if producing convulsive movements positive for upper motor neuron lesion)

……

Soto Hall (Lift head with other hand on the chest) …… Check to localize pain in vertebra ……

Postion of pain …… Achilles DTR …… left …… right ……

Derifield …… leg length …… 90degrees …… Can patient touch nose from extended arm position with eyes closed? Yes/No

Turn head to left …… Turn head to the right ……

Rhomberg's sign …… Heel walk …… Toe walk …… Adams position ……

Can the patient walk on the spot with eyes closed? Yes/No

Sitting position

Foramina Compression test…… Flex head to the side of the pain ……

Aggravate? ……Yes/No

Extensor Carpi Radialis test …… positive …… negative …… Extensor digitorum reflex ……

Vibratory tests ……

Additional Notes

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……

Our practice specializes in treating problems of the spine and associated disorders of the nervous system.

Please (circle) and complete the following:

I GIVE / DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.

CONSENT FORM

Changes to the law now require all practioners who manipulate the spine to warn patients of material risks. In very rare circumstances some treatments to the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approximately one in 5.9 million neck manipulations. Haldeman vo. 24-8 1999). If any adjustments (manipulations) are required you will be tested beforehand.

Other very slight risks include strain/sprain to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). (Dvorak study in Principles and Practice of Chiropractis, Haldeman 2nd Edition).

Chiropractic adjustments (manipulations) of the spine are internationally recognized as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation JMPT 1995 Manga Report Ontario Ministry of Health 1993).

You have the right to decline part or all of the treatment that the Chiropractor offers as well as a right to a second opinion at any time.

The Chiropractor retains the right, if necessary, to exchange information with your medical practitioner or health practitioner. This information will be kept confidential as required under the Privacy Act.

If you have any questions related to the treatment you are about to receive, please speak to the chiropractor.

I have discussed the above information with the chiropractor and give my consent to treatment.

Signature ……

Print Name ……

Date ……