Byford Healing Arts

Patient Details

Surname: ____

First Name/s: ____

Date of Birth: ____________________________

Contact Details

Telephone:	Home: ___________________________	Work: ____________________________
	Mobile: __________________________	Other: __________________________

E-mail: ____

Street Address: ____

Town/Suburb: ___________________________ Postcode: ________________________________

Name of Regular GP:____

How did you find out about this clinic? (Tick ✓ most appropriate)

☐ Paper ad	☐ Doctor	☐ Friend
☐ Flyer	☐ Physiotherapist	☐ Patient
☐ Street sign/banner	☐ Podiatrist	☐ Facebook
☐ Newsletter	☐ Website	☐ Other ________________

Who Referred you to this clinic? ____

Do I have permission to thank them? Yes / No

Special Patient Information

All treatments carry some degree of risk of injury. Every person who is treated in this clinic is thoroughly evaluated for all possible risks. We use different techniques to suit different ages and body types

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

I have read, and understand the above information, and I am aware that I may ask questions at any time regarding the proposed treatment. I hereby give my consent for treatment.

Patient Signature: ____ Date: _________________

Parent Guardian Signature: ___________________________________ Date: _________________

Chiropractor Signature:_____________________________________ Date: _________________

Patient History

Name: ___________________________________ Date: ____________________________________

Description of Occupational and Recreational Activities: (BE DETAILED…)

____
____
____
____

Major Accidents: Related and unrelated to chief complaint: for example; falls from horses, out of trees, motor vehicle accidents, fractures; even if treatment wasn't sought. (Please state when and nature of)

____
____
____
____

Surgeries and Hospitalizations: (Please state when, where and reason for)

____
____
____

Major Illnesses, Diseases or Chronic Conditions: (e.g. hay fever, sinuses, poor digestion, etc.)

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____
____

Illnesses/Diseases of Close Relatives: (e.g. mother– heart disease & high blood pressure)

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____
____

Current Medications/Supplements:

____
____

Chief Complaint:

____
____

Previous Treatments:

____
____

Other Complaints:

____
____

Important: Please ✓ all present symptoms

Name: ____________________________

Date: ____________________________

Head:

- ☐ Headache or Migraine - frequency
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing or Buzzing in ears

Neck:

- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding or Popping sounds in neck
- ☐ Arthritis in neck

Shoulders:

- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R–L)
- ☐ Arthritis (R–L)
- ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R–L)
- ☐ Muscle spasms in shoulders

Arms & Hands:

- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers "go to sleep"
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

Mid-Back:

- ☐ Mid-back pain
Location ________________________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

Chest:

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Change in Breast Shape
- ☐ Irregular heart beat

Abdomen:

- ☐ Nervous stomach
- ☐ Foods can't eat ___________________
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Haemorrhoids
- ☐ Indigestion
- ☐ Heartburn

Low Back:

- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumber
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
____
- ☐ Pain relieves when: __________
____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

Hips and Pelvis

- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)

Legs and Feet

- ☐ Pain down leg (R-L or both)
- ☐ Knee pain (R-L)
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R-L)
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)

General:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run down
- ☐ Normal sleep ___________ hrs/night
- ☐ Loss of sleep ___________ hrs/night
- ☐ Loss of weight __________ kg
- ☐ Gain weight ____________ kg
- ☐ Coffee ________________ cups/day
- ☐ Tea __________________ cups/day
- ☐ Cigarettes _____________ smoked/day
- ☐ Other ___________________________
- ☐ Diabetes
- ☐ Hypoglycaemia

Remarks/ Comments:

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