MY BALANCE MATTERS

Chiropractic Patient Health Questionnaire

NAME: Title_____ First Name _____ Surname _____

GENDER: ☐ Male ☐ Female ☐ Other

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

Suburb _____ State _____ Postcode _____

PHONE Mobile_____

EMAIL ADDRESS: _____

FOR POSTURE SCREEN: Height_____ cm Weight_____kg

IS YOUR CHIROPRACTIC CARE COVERED BY: **VETERAN'S AFFAIRS, WORKCOVER, TAC OR EPC?**

☐ NO ☐ YES (please present your card, referral or claim number to us)

OCCUPATION: _____

FAMILY MEMBERS:

Name(s)	Age(s) of Family members
_____	_____
_____	_____
_____	_____

DO YOUR CHILDREN HAVE ANY HEALTH ISSUES?

_____

EMERGENCY CONTACT

Name _____Mobile_____ Relationship_____

HOW DID YOU HEAR ABOUT OUR WELLNESS CENTRE?

☐ Google Search ☐ Our Signage ☐ Website ☐ Facebook/Instagram

Another Health Professional, please specify: _____

Friend/Family Member, please specify: _____

HOW CAN WE HELP YOU TODAY?

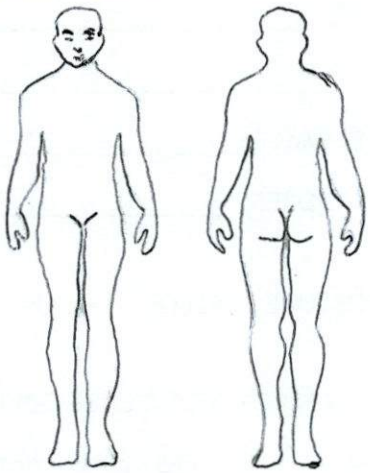
Please list all your current symptoms and rate on a scale of 1-10
(1=little pain/discomfort and 10=significant pain or discomfort)

Symptom	Months	Rating	Symptom	Months	Rating
1._____	_____	_____/10	4._____	_____	_____/10
2._____	_____	_____/10.	5._____	_____	_____/10
3._____	_____	_____/10.	6._____	_____	_____/10

MARK ON THE DIAGRAM EVERYWHERE THAT YOU FEEL PAIN OR SYMPTOMS

What does it feel like?

- ☐ Numbess
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____



Is the pain referring to other areas of your body? ☐ No ☐ Yes: Where? _____
Is the condition getting worse? ☐ No ☐ Yes
Have you seen anyone else for this condition? ☐ No ☐ GP ☐ Chiro ☐ Physio ☐ Osteo

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS?

SYMPTOM / CONDITION	NOW	PAST	SYMPTOM / CONDITION	NOW	PAST	SYMPTOM / CONDITION	NOW	PAST
ADD/ADHD			Elbow/Wrist/Hand issues			Nerve Pain		
Allergies			Fatigue /Low Energy			Osteoporosis		
Asthma/Breathing issues			Fainting			Operations/Surgery		
Arteriosclerosis			Fibromyalgia			Osteitis Pubis		
Arm or Shoulder Pain			Foot or Ankle troubles			Poor Posture		
Anxiety			Frequent colds or Flu			Poor Circulation		
Arthritis OA. RA.			Gout			Poor Immunity		
Balance Troubles			Headaches			PMS Syndrome		
Bedwetting			Hepatitis			Period Pain		
Bowel trouble			Insomnia/Poor Sleep			Pregnancy		
Cardiovascular issues			Jaw Pain / TMJ Issues			Reproductive issues		
Carpal Tunnel Syndrome			Joint or Disc Replacement			Rib or Chest pain		
Chronic Pain			Knee or Hip pain			Ringing in ears		
Cancer			Lower Back Pain			Sciatica or Leg pain		
Caesarean			Miscarriage(s)			Shortness of Breath		
Dizziness			Migraines			Sinus Trouble		
Depression			Motor Vehicle Accidents			Shingles		
Deep vein thrombosis			Neck Pain			Stroke(s)		
Diabetes			Numbness / Tingling			Thyroid Trouble		
Digestive issues			Nausea			Urinary issues		
Eczema			Nervousness			Other		

IMPACT OF YOUR SYMPTOMS

How are these symptoms/conditions interfereing with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work				
Exercsise				
Recreation				
Relationships				
Sleep				
Self-Care				

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy				
Attitude				
Patience				
Productivity				
Creativity				
Other				

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

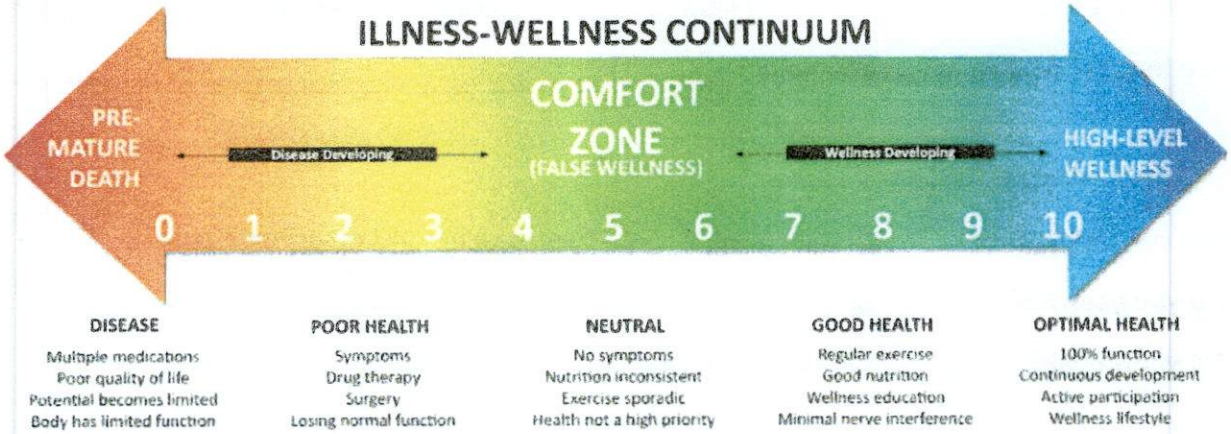
Not committed Committed

What do you think will happen if you did nothing? _____

Please tick any emotions that you feel on a regular basis (more than once a week):

☐ Frustration ☐ Depressed ☐ Anxious ☐ Cynical ☐ Nervous

PATIENT WELLNESS ASSESSMENT



On the diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

WHAT ARE YOUR HEALTH GOALS?

Immediate (4 weeks) _____

Short Term (12 weeks) _____

Long Term (12 months) _____

DAILY ACTIVITIES

Do your daily activities involve: ☐ Sitting ☐ Walking ☐ Heavy lifting ☐ Phone use
☐ Writing ☐ Driving ☐ Manual work ☐ Standing
☐ Desk work ☐ Emotional Stress ☐ Repetitive tasks

Sports / Hobbies: _____ ☐ Currently play ☐ Used to play
_____ ☐ Currently play ☐ Used to play
_____ ☐ Currently play ☐ Used to play

Do you play a musical instrument? ☐ No ☐ Yes, please list: _____

Do you read for prolonged periods? ☐ No ☐ Yes ☐ Books ☐ Computer/tablet

SLEEP HEALTH

Do you sleep well? ☐ No ☐ Yes. How many hours per night? _____

Sleeping posture: ☐ Side ☐ Back ☐ Stomach

How old is your: Pillow:_____years Mattress: _____years

Are they supportive and comfortable? _____

GENERAL HEALTH SUMMARY

Are you trying to: ☐ Gain weight ☐ Lose weight ☐ Conceive a child

Do you exercise? ☐ No ☐ Yes: ____ Times per week?

Do you smoke? ☐ No ☐ Yes. How many per day _____

Do you have any pre-existing health conditions diagnosed by a GP, specialist or other practitioner?
Provide details: _____
_____

Please list any medications or supplements that you currently take:

Medication/Supplement Name	Dosage	Reason for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST EXPERIENCE WITH CHIROPRACTIC CARE

Have you received Chiropractic care before? ☐ No ☐ Yes

If yes, when was your last adjustment? _____ Chiro's name: _____

Were you happy with the service provided? ☐ No ☐ Yes. Why? _____

Have you ever had spinal x-rays, MRI or CT scans taken?

☐ No ☐ Yes, when and what? _____

FEMALES: are you currently pregnant, breastfeeding or trying to conceive?

☐ No. **If yes, are you**

- ☐ Pregnant. How many weeks?_____
- ☐ Breastfeeding
- ☐ Trying to conceive

MEDICAL HISTORY DISCLOSURE

Please note, we require you to provide us an accurate summary of your previous and current medical history (including medications) in order to determine how to treat you safely and most effectively.

We also require you to disclose to us if you have had COVID 19 or the COVID 19 vaccine within 7 days of your appointment. We do not recommend being adjusted on the same day as your vaccine, however we do recommend the day before.

PRIVACY POLICY

In accordance with the Privacy Act, all information relative to you and your case is held in total confidence. However, your consent is necessary to allow us to exchange information between the Chiropractors, or other health care practitioners if appropriate, within or outside this practice to ensure the most effective management of your condition. We will not release any information regarding your history or treatment to another medical or healthcare practitioner without your written consent.

CANCELLATION AND RESCHEDULE POLICY

You will receive a text message upon booking each appointment and a text reminder 3 days prior to each appointment. We will assume you are coming to your scheduled appointments unless you call us

Repeated missed appointments, late cancellations or reschedules made less than 48 hours prior to the appointment time will unfortunately result in a missed appointment or late cancellation charge equivalent to the full cost of your appointment.

I have read and understand this policy.

PATIENT SIGNATURE: _____ PRINT NAME: _____

CONSENT TO CHIROPRACTIC CARE

Treatment with mobilization, manipulation or manual adjustment to the spine and pelvis may occasionally cause **temporary** soreness (24-48 hours) in about 30% of patients.

The most common side effects or risks of manual adjusting are:

- **Fatigue,** headache, dizziness, euphoria or light headedness
- Temporary soreness in the neck, back or extremities
- Muscle or joint tightness (like post exercise DOMS)
- Call us if you have any concerns on day 1 or 2 after your adjustment

Rare side effects:

- Ligament, rib joint or disc sprain

Very rare risks:

- Vertebra or rib fracture.
- Worsening of lower back or leg pain / aggravation of underlying disc pathology
- Cauda Equina Syndrome (when the nerve roots in the lumbar spine are compressed, affecting sensation and movement of the legs)

In **extremely rare** circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. (Current literature states this to be approximately 1 in 5.85 million neck manipulations according to Haldeman, et al, Spine vol. 24-8 1999).

Whilst this has never occurred in this practice, we are still required to inform you of these rare risks. If any adjustments (manipulations) are required to your neck, your vertebral artery patency will be tested beforehand. If you do not consent to manual cervical adjustments, alternative techniques will be used.

If you have any questions related to the treatment you are about to receive, or alternative approaches, please discuss with your Chiropractor.

You can change or withdraw your consent at any time.

I acknowledge that I understand the risks associated with Chiropractic treatment and spinal manipulation, and have had the opportunity to discuss these risks with my Chiropractor.

I have discussed the above information with my Chiropractor and give my consent to treatment:

Please sign on the day of your appointment

PATIENT SIGNATURE: _____ PRINT NAME: _____

CHIROPRACTOR'S SIGNATURE: _____ DATE: _____

Purpose of Treatment

Chiropractic Neurorehabilitation aims to assess and treat neurological function through various interventions. The goal of care is to improve overall neurological health and functional capacity, enhance cognitive capability, alleviate symptoms related to neurological conditions such as anxiety and relieve suffering.

Description of Treatment

I understand that the treatment may include, but is not limited to:

- Neurological assessments
- Balance Assessment
- Head and Eye movements
- Cognitive training
- Physical therapy
- Therapeutic exercises
- Nutritional counselling
- Lifestyle Medicine counselling
- Functional Medicine support (optional, as per discussion)
- Neuromuscular re-education and Postural Awareness
- Modalities such as LASER, Vibration, Vagal Nerve Stimulation, Activator, Taping

Potential Benefits

- Improvement in neurological function
- Enhanced balance and coordination
- Reduction in pain and discomfort
- Decrease in symptoms of anxiety
- Overall better quality of life

Potential Risks

Chiropractic Neurorehabilitation treatment is generally considered safe, however some potential risks may include:

- temporary discomfort, fatigue, or feeling a sense of light headedness. In rare cases, particularly with people who have a very complex life experience, more notable adverse effects may occur such as a sense of dizziness or distortion from your local surroundings.

- N.B. these are very temporary effects and typically resolve with simple breathing and eye/head exercises shown to you on your first visit, and generally resolve within hours. In some people they may last up to 2 days. They occur as a result of your brain adjusting to your body in different surroundings and referencing your 'old GPS maps' to your updated senses. A bit like Google Maps updating after road works, it's a little different and better.

Alternatives

I have been informed of alternative treatments and approaches, including soft tissue therapy and traditional Chiropractic therapies, and I understand that I can choose any of these options at any time

Responsibilities

I agree to:

- Do the suggested exercises at least once a day in the morning (please advise if you were unable to get these done - no shame - it is ok - it just changes the therapy time line)

- Follow the treatment plan as discussed (people typically need 3 long sessions before the changes start to 'bed in', and 6 - 8 sessions to alleviate roughly 80% of the presenting concerns, dependant upon complexity)

- Communicate any concerns or side effects experienced during treatment

- Provide accurate health information and update my practitioner on any changes in my condition or sensory experience

Consent

I have read and understood this consent form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I consent to receive treatment under the guidance of my practitioner, Dr Anthony Briggs.

Patient Signature:

CENTRAL SENSITIZATION INVENTORY: PART A

Name: _____ Date: _____

Please circle the best response to the right of each statement.

Mid B	1	I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always
Mid B	2	My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
Limbic	3	I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
B.G	4	I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
ANS	5	I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
Limbic	6	I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
Mid B	7	I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
ANS	8	I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
Cortex	9	I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
	10	I have headaches.	Never	Rarely	Sometimes	Often	Always
Limbic	11	I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
Mid B	12	I do not sleep well.	Never	Rarely	Sometimes	Often	Always
Cortex	13	I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
ANS	14	I have skin problems such as dryness, itchiness, or rashes.	Never	Rarely	Sometimes	Often	Always
Limbic	15	Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
Cortex	16	I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
ANS	17	I have low energy.	Never	Rarely	Sometimes	Often	Always
B.G	18	I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
B.G	19	I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
	20	Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
	21	I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
B.G	22	My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
Cortex	23	I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
Cortex	24	I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
Limbic	25	I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always
						Total=	

Rev. 6-3-2015

CENTRAL SENSITIZATION INVENTORY: PART B

Name: _____

Date: _____

Have you been diagnosed by a doctor with any of the following disorders?

Please check the box to the right for each diagnosis and write the year of the diagnosis.

		NO	YES	Year Diagnosed
1	Restless Leg Syndrome			
2	Chronic Fatigue Syndrome			
3	Fibromyalgia			
4	Temporomandibular Joint Disorder (TMJ)			
5	Migraine or tension headaches			
6	Irritable Bowel Syndrome			
7	Multiple Chemical Sensitivities			
8	Neck Injury (including whiplash)			
9	Anxiety or Panic Attacks			
10	Depression			