Adult History Forms -to fill out and bring to Jackson Chiropractic

Last name: _____ **First Name:**_____ **email :**_____

Address: _____ Postcode _____

Home Phone no: _____ Work/mobile: _____ Date of birth: _____Age ____

Height_____ Weight:_____

Please describe your occupation fully: _____

Marital status: _____ No. of children: _____ Referred by _____

Today's Date _____Recreation/Hobbies/Sport: _____

Emergency contact name: _____Relationship:_____ Phone: _____

Part 1: Health Concerns and symptoms (Practitioner: Dr Fiona Boyle B. App. Sc. (Clinical Science) B. C. Sc. (Chiropractic Science)

1. **Main reason for visit?**_____

_____

_____

Please circle Sharp Dull Ache Stabbing Burning Pins & Needles Numbness Getting worse/better Stiffness Weakness Radiating Throbbing sharp Catching Constant Intermittent Fluctuating Getting worse/Better Stable

2. When did this begin? _____Recent Trauma_____

3. **PLEASE RATE *0- does not* Impact *me*** ***1- slightly* Impacts *me*** ***2- moderate* Impact** ***3- drastic* Impact**

Impact on work 0 1 2 3 Impact on recreation/play 0 1 2 3 Impact on rest/sleep 0 1 2 3

Impact on walking 0 1 2 3 Impact on sitting 0 1 2 3 Impact on exercise 0 1 2 3

Concern about total health 0 1 2 3 Concern about particular symptom/condition 0 1 2 3

4. Awareness during the day? 0 1 2 3; at night? 0 1 2 3

5. What makes it better_____

6. What makes it worse_____

7. Do you ever forget about/not feel your condition? **Yes/No** When/Why? _____

_____

8. What have you done about it and what were results ?_____

_____

9. Why do you think this has happened or continues to happen to you? _____

10. Please circle "Red Flags" Night sweats Sudden Weight loss/gain Unexplained fatigue Groin and inner thigh Paraesthesia (altered sensation, pins and needles, numbness) Bladder/Bowel loss of control Unexplained bleeding

11. Systems review: Problems with Heart Lungs Digestion Immunity Brain Skin Reproductive Eyes Ears Cancer

Describe:_____

Previous Chiropractor's Name:_____**Phone:**_____**Address:**_____**a)**

Why did you go? _____**What did he/she do for you?** _____

b) How often did you go? _____Where you pleased? **Yes/No**_____

c) When was your last visit? _____Does your family receive chiropractic care? **Yes/No**

2. Supplements_____

GP/Specialist/health practitioners name, address, phone _____

When was your last visit?_____

Reason for the visit(s)? _____

What was done or suggested? _____

Please list medications (prescriptions or non-prescription) you have taken within the past two months, include panadol etc. _____

Part 2: History (from birth)

1. Past long term medications (eg contraceptive pill, Ventolin, antibiotics) Please list or attach list

_____

2. Please list time and area of X-Rays or scans of any body part (eg MRI)_____

_____

3. Please list all surgeries and approx. dates_____
4. Broken bones/fractures, sprains: Please list:_____
5. Please circle therapies used: Massage/Myotherapy Osteopathy Acupuncture Homoeopathy/Naturopathy Physio
6. **Current treatment**:_____
7. Exercise, meditation, nutritional or dietary program: describe: _____

_____

When stressed, what do you do?_____

Part 2) 1: Stress /Injury Survey: Please circle the following ratings and describe (birth to current)

1) Overall Physical stress, trauma: ***no awareness of physical stress*- 0 1 2 3- *extremely stressful***

falls **- 0 1 2 3** injuries**- 0 1 2 3** work in repetitive postures**- 0 1 2 3**

accidents**- 0 1 2 3** lifting**- 0 1 2 3** vehicle accidents**- 0 1 2 3**

difficult birth**- 0 1 2 3** physical abuse**- 0 1 2 3** Motor/push bike injuries**- 0 1 2 3**

Sports injuries eg football/ fights/ Knocked out/concussion/ Surfing/ Skiing/ Skating **- 0 1 2 3**

_____

_____

2) Overall Emotional/Mental stress: ***no awareness of mental stress* -0 1 2 3-*extremely stressful***

loss of loved ones**- 0 1 2 3** rapid change in life situation **- 0 1 2 3** move of home/ school**- 0 1 2 3**

mental, emotional, sexual abuse**- 0 1 2 3** legal or financial concerns**- 0 1 2 3**

Separation/divorce**- 0 1 2 3** relationship stress**- 0 1 2 3** stress of being ill**- 0 1 2 3**

_____

3) Overall Chemical stress: ***no awareness of chemical stress*- 0 1 2 3-*extremely stressful***

chemical/drug (include medicines, alcohol, cigarettes) **- 0 1 2 3** fumes/pollution **- 0 1 2 3**

takeaway/processed food/ colours, flavours, preservatives **- 0 1 2 3**

_____

Part IV: Goals consistent with studies of Network Spinal Analysis (NSA) care, a form of chiropractic.

1] physical symptom improvements 2] emotional/mental symptom improvement

3] better ability to respond to stress 4] Improvement in enjoyment & quality of life

5] better ability to make valuable, healthy choices

Please note: these results have been experienced by others after a minimum of twelve visits over one month. Depending on your case and goals you may be recommended a visit frequency of 1 to 3 appointments per week. Every person responds differently to care, individual results may vary, and people often feel a lot worse before they feel better.

I have read and understood this form and have provided information to the best of my ability.

Name……..……Signature……Date……..

Pakenham Practice: 34 Jamie Ct Pakenham VIC 3810 Warragul Practice: 5/11 Pearse St, Warragul 3820
W jacksonchirounwind.com E jchiro@netspace.net.au P 03 5941 5431 M 0409 185 055
ABN 86 557 296 050 ACN 081 669 712

Info & Consent form - sign & bring to Jackson Chiropractic

Note: be aware that **Network care is different** from other types of chiropractic care
-**contacts to your spine are light touch** and very precise. They may be difficult to feel
-**respiration is used** with stretching to allow improved body movement
-**there is no manipulation** or "crunching", there is no massage
-**large muscles relax first** and improve tone to allow deep muscles to unlock
-**joints release as your body improves muscle tone**, often with a popping noise
-**release of tension is spontaneous and automatic** once your system has connected more
-**releases of stored pain, toxins and emotions** are common during and after visits, and are often severe. Major changes may make you feel a lot worse for a few days.
-**the skills you gain can be used at all times**, e.g. at home, work, when resting.

Please ask as many questions as you need, you may call, text, email Dr Fiona out of your visit time
The open plan room is believed to improve results of unwinding and relaxation
If you prefer the private room at any visit or for all visits please advise when booking
Chiropractic care is not a substitute for medical diagnosis or emergency medical care
health information is private and will not be shared with any third party without consent
Wear exercise type clothing. Avoid wearing strong perfume and aftershave
Posture photographs are taken, please wear fitted singlet or crop top, bike pants or shorts, bathers
Please don't smoke, chew gum, take painkillers, or anti-inflammatories just before your visit
Make sure you are well hydrated and have been to the toilet
Please call as early as possible if you need to change appointment times

Payment is expected at your visit; cash, cheque and EFT/credit and HICAPS available
Direct deposit (preferably in advance, please bring printout of receipt or text)
Account name: Jackson Chiropractic P/L CBA BSB 06 3733 Account number: 1031 1623

Fee Structure for consultations	***Concession/Child***	**Full fee**
First visit – History, Examination and Adjustments…… Includes foot scan and posture photos, movement video analysis	***…$110***	**$120**
Regular single visit……	***$55***	**$60**
Pre-payment option for 10 visits-save $50……	***$500***	**$500**
Regular Family visit (4 or more family members)…… Concession fee for 4 members, plus others complementary	***$220*** ($55 x 4)	
Re-examination: Review, adjustment, report…… Includes posture photos, movement videos. *Initially every 8 to 10 visits*	***$110***	**$120**

(If refund of pre-paid fee is required, discount is removed before balance is paid to you)

▪I have understood this information, and agree to give my informed consent for care
I understand that contacts will be gentle, precise, explained in advance and there will be time for rest and integration between contacts. It may involve positioning and stretching of limbs or my spine.
Occasionally an adjusting instrument may be used with a very fast tap of low force.
It will involve my participation of awareness, breathing patterns, stretching, movement into comfortable positions, and feedback to my chiropractor during and after visits.
The moment I feel that any treatment needs to be explained further, modified or stopped, I will communicate this.

Name…… Signature…… Date……

Permission given for Dr Fiona to discuss your progress with-the person who referred you? **Y/N**; your family? **Y/N**