



Vida Chiropractic
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Welcome to Vida Chiropractic!

Personal Information

Full name:		Date:	
Address:			
Home phone:		Work phone:	
Mobile phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children: What are their ages?		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital status: M S W D		Spouse/guardian name:	
Occupation:			
Spouse's Occupation:			
Do you have health insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you a pension card holder? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Who may we thank for referring you?

Have you ever received chiropractic care before? If so, from whom? And when?

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?
2. Type:	When?
3. Type:	When?
4. Type:	When?

Have you had any accidents and/or injuries: car, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Do you smoke? If so, how many per day?

Do you drink? If so, how often?

Health History

Please mark the following conditions you may have had or have now:

Neck pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Numbness in fingers <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Nervousness <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Stiff Neck <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Shoulder Pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Tension & Irritability <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Headaches <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Cold Feet/Hands <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Fatigue <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Sleeping Problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Dizziness <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Loss of Smell/Taste <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Depression <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Fainting <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Cold/Flu <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Lower Back Pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Ears Ring <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Allergies <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Pins & Needles in Legs <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Balance Loss <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Pain in mid-spine <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Shortness of breath <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Numb toes <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Cold Sweat <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Weight Problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Chest Pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Hearing Problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Stomach/Digestive Problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Fever <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Light Bothers Eyes <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Constipation or Diarrhea <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Loss of Memory <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Menstrual Pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Pins & Needles in Arms <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Diabetes <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Asthma <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition

Other (please explain) _____

What are your hobbies and interests?

Do you exercise or play sport? If so, what type and how often?

Please Rate your Wellness

How would you rate your overall health out of ten? 1 5 10
 |-----|-----|-----|

How would you rate your stress level out of ten? 1 5 10
 |-----|-----|-----|

What would you like your health to be out of ten? 1 5 10
 |-----|-----|-----|

Informed Consent

There are many concerns about the safety of procedures we undergo routinely, the environment we live in, and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Vida Chiropractic will enhance your experience.

Most people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.

If you are (or have been) taking anticoagulant (blood thinning) medication or steroids then it is important to tell your chiropractor this prior to commencing care.

There are always risks associated with any therapeutic intervention! Regarding manual spinal adjustment the risk of permanent injury or death is approximately 1 in 2,500,000. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for aches and pains is approximately 3 in 1000. Statistically there is more chance of being hit by lightning than experiencing permanent damage or dying from a manual adjustment.

We must explain these risks to you so that you can make an informed decision about commencing, or continuing your care. If you have any further concerns please ask your chiropractor.

The adjustments and care you receive here at Vida Chiropractic will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

When you refer friends and family to see us for chiropractic care, we like to recognise your trust and confidence in us by acknowledging you on a notice. Please let us know if you would prefer not to be thanked publicly.

I have read the above and give authority to Vida Chiropractic to commence/continue chiropractic care for either myself or my dependent. (whichever is applicable)

Signed: _____

Name (please print): _____

Witness: _____



My Health Summary

Name: _____

Date: _____

Assessment number: 2 3 4

My main health concern/symptom: 0 = best, 10 = worst. My symptom is:



My other major health concern/symptom: 0 = best, 10 = worst. My symptom is:



I would rate the overall movement and flexibility in my neck: 0 = flexible, 10 = rigid



I would rate the overall movement and flexibility in my mid back: 0 = flexible, 10 = rigid



I would rate the overall movement and flexibility in my low back: 0 = flexible, 10 = rigid



I would rate my overall pain level in my neck: 0 = mild, 10 = worst



I would rate my overall pain level in my mid back: 0 = mild, 10 = worst



I would rate my overall pain level in my low back: 0 = mild, 10 = worst



I am able to notice tension and release it in my body: 10 = not at all, 0 = I can completely notice tension and release it



My overall energy levels feel: 0 = great, 10 = bad



My overall posture feels: 0 = great, 10 = bad



My ease in standing straight feels: 0 = great, 10 = bad



I feel emotions like anger, depression, unhappiness, hopelessness: 0 = never, 10 = frequently



I feel emotions like joy, happiness, gratitude, hope: 0 = frequently, 10 = never



I sleep deeply and wake up feeling rested: 0 = yes, 10 = no



I handle life's stressors: 0 = very well, 10 very badly



My self perception is: 0 = excellent, 10 = terrible



Please turn over