Confidential Patient Information Form

This form will take about 15 minutes to complete.

Headache and Neck Pain Clinic
evidence-based natural medicine

To ensure your privacy, this Practice adheres strictly to the National Privacy Principles of the Commonwealth of Australia privacy legislation. Your health information is collected by us only with your consent and as necessary for the proper and effective treatment of your condition. Health information about you will not be released to any other party including other treating health providers without your consent. You may review your health information with your treating provider at any time and are entitled to access your health records for this purpose. If you have any concerns about the confidentiality of your health information, please feel welcome to discuss these with your treating provider.

Family name: _____ Given name(s): _____
Date of Birth: _____ Male: _____ Female: _____ Other: _____
Address: _____
Suburb: _____ Postcode: _____
Phone: (M) _____ (H) _____ (W) _____
Email: _____
Occupation: _____ Employer: _____
Emergency contact: _____ Relationship: _____ Phone: _____
Who is your GP? _____
Clinic name: _____ Phone: _____
Address: _____
Suburb: _____ Postcode: _____
How did you find out about this Clinic? _____
Why have you come to this Clinic? _____
What scans have you had (eg neck x-ray, head MRI)? _____
Detail any test results (eg blood test - low iron): _____

Please bring scans and test results to your first visit

Place an 'X' in the relevant response and add details where prompted. Leave blank if not applicable

Is this a claim through:	**Yes**
Medicare - your GP has prepared and given you a Chronic Disease Management (CDM) plan	
Department of Veterans Affairs (DVA) - card number: _____	
WorkSafe - claim number: _____	
Traffic Accident Commission (TAC) - claim number: _____	

Please bring documentation to your first visit. You are responsible for payment until the claim has been accepted. If payment is declined by an insurer or authority you are responsible for outstanding costs.

List treatments and place an 'X' in the relevant response

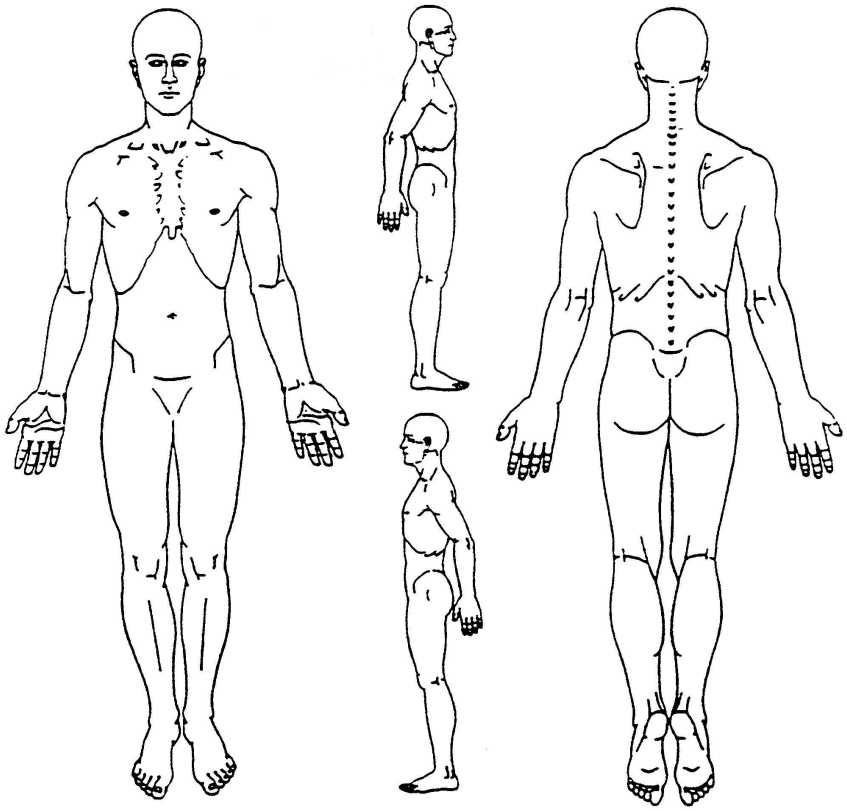
What treatments have you tried in the past?	**Effective**	**Partly effective**	**Not effective**

Describe the pain or sensation that you are experiencing. Place an 'X' in the relevant response(s)

Sensation	Yes	Sensation	Yes	Sensation	Yes	Sensation	Yes
Numbness		Pounding		Tightening		Stabbing	
Pins and Needles		Exploding		Pressing		Burning	
Tingling		Squeezing		Sharp		Shock-like	
Throbbing		Pressure		Dull		Other: _____	

Rate your level of pain from 0 to 10, where 0 = no pain, and 10 = the worst pain you have ever experienced: _____ / 10

Indicate on the diagram where you feel pain or other sensations:
Many PDF readers have a drawing function



What are your goals that you would like to achieve with treatment:

General health history

Detail travel in the last 3 months: _____
If you wear glasses or contact lenses when was your last last eye examination: _____
List your allergies: _____
Have you been pregnant within the past 3 months? Yes: _____ No: _____ Not applicable: _____
What regular sport or exercise do you do? _____
How many days per week? _____
Are you following a specific diet (eg vegetarian, ketogenic): _____

How many…	**Number**
drinks of alcohol do you have per day?	
cigarettes do you smoke per day?	
caffeinated drinks do you consume per day (eg coffee, tea, energy drinks, cola drinks)?	

List all accidents, illnesses, fractures, surgeries and hospitalisations:	**Year**

List medications and doses that you take, and the reason for taking them *(**include prescribed and over-the-counter medicines, natural medicines, supplements, contraceptives or hormone replacement therapy (HRT) medications)*:**

Place an 'X' in the relevant response(s), or leave blank if not applicable

Have you ever experienced:	Yes		Yes
Anaemia or low iron levels		Vascular disorder	
Vitamin B12 deficeincy		Hypercalcaemia (high blood calcium levels)	
Lung disease		Diabetes or abnormal blood sugar levels	
Bone, joint or connective tissue disorder		Obesity or overweight	
Rheumatologic disorder (eg Rheumatoid Arthritis, gout)		High blood cholesterol or triglycerides	
Thyroid disorder		Depression	
Cancer		Anxiety	
Heart disease, heart attack, angina		Significant motion sickness	
Hypertension (high blood pressure)		Seizures	
Stroke, transient ischaemic attack (TIA), or aneurysm		Immune system disorder	

Have you experienced IN THE PAST 6 MONTHS:	Yes		Yes
Skin changes		Dizziness, vertigo or unsteadiness	
Swelling		Fainting or loss of consciousness	
Abnormal bleeding or bruising		Change in bowel function	
Chest pain		Change in bladder function	
Shortness of breath		Memory loss	
Neck pain		Depression	
Back pain		Mood changes	
Joint pain		Difficulty seeing	
Muscle weakness		Difficulty hearing	
Head or neck injury (eg concussion, whiplash)		Difficulty speaking	
Palpitations (abnormal heart beat)		Difficulty swallowing	
Fevers or chills		Night sweats	
Nausea or vomiting		Unexplained weight loss or gain	

Place an 'X' in the response that best describes how often you experienced the situation in the past 4 weeks

Insomnia Rating Scale ≥ 9	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
Did you have trouble falling asleep?	0	1	2	3	4
Did you wake up several times at night?	0	1	2	3	4
Did you wake up earlier than you planned to?	0	1	2	3	4
Did you have trouble getting back to sleep after you woke up too early?	0	1	2	3	4
	Very sound or restful	**Sound or restful**	**Average quality**	**Restless**	**Very restless**
Overall, was your typical night's sleep during the past 4 weeks?	0	1	2	3	4

WHIIRS score:

List siblings, parents or grandparents that have been diagnosed with the following conditions:	Relative (eg father, mother, sister, brother, maternal or paternal grandfather, maternal or paternal grandmother):
Blood disorder	(eg Mother)
Heart condition (eg heart attack, heart failure)	
Hypertension (high blood pressure)	
Diabetes	
Stroke	
Autoimmune disease	
Genetic disorder	
Cancer	
Nervous system disorder (eg epilepsy, migraine)	
Muscle, bone, joint or connective tissue disorder	
Rheumatologic disorder (eg Rheumatoid Arthritis, gout)	
Other: _____	
Other: _____	

The following questions relate to headaches and migraines. If you do not experience these go to page 6

Place an 'X' in the relevant response(s), and add details when prompted

The following questions relate to your current, or most recent headache SNOOP4 (Papilloedema)	Yes	No
Do you have a general feeling of being unwell (eg fever, weight loss, night sweats, joint pains)? S		
Is your headache associated with a stiff neck (reduced ability to move your head and neck)? S		
Have you experienced vision, sensory, movement or language changes lasting longer than 1 hour? N		
Have you experienced a seizure with the headache? N		
Does your headache **cause** you to wake up from sleep? N		
Are you 50 years of age or more? O		
Is this your first headache? O		
Did it start very suddenly like a thunderclap? O		
Is it the worst headache you have ever experienced? P		
Has there been a recent change in headache pattern (eg more severe, frequent, or lasting longer)? P		
Does it get worse with straining, coughing, sneezing, laughing, sexual activity or physical exertion? P		
Does it get worse when bending forward? P		
Does it get worse sitting or standing up after lying down? P		

Place an 'X' in the relevant response(s)

ID Migraine (2/3=93%PPV)	Yes	No
In the past 3 months has a headache limited your activities for at least 1 day?		
When you have a headache do you feel nauseated or sick to your stomach?		
When you have a headache does light bother you?		

Consent to Procedures

Chiropractic treatment, including spinal manipulation or adjustment, has been reported to be an effective treatment for spinal pain, some headaches and other similar symptoms. Chiropractic care has stood the test of time. The risk of injuries or complications from Chiropractic treatment is often lower than that associated with many medical and other treatments. The aim of the treatment is always to improve the patient's health, however, before undergoing a treatment a patient should understand the relevant factors in relation to it.

The following risks are associated with treatment:

1. In a minority of cases the treatment may not be successful and you may be in the same position you are now.

2. Although uncommon the treatment may make your condition worse:

    a) In the case of treatment to the spine and pelvis, temporary soreness occurs in about 1 in 3 patients; strains and sprains to the muscles, ligaments and other soft tissues may occur but are uncommon; rupture to discs between the spinal vertebrae are uncommon but in these cases nerve pain can ensue with radiation of pain into the arms, trunk or legs and in rare instances this can cause permanent disabling pain and weakness in an arm or leg, and in very rare instances bowel, bladder and penis erectile function can be impaired; another rare event is fracture to the ribs.

    b) In the case of manipulation or adjustment to the neck there have been reported additional cases of injury to arteries in the neck. These are very rare events (approximately 1:100,000 patients to 1:400,000 manipulations) but if they occur they have been known to cause stroke sometimes with serious injury such as quadriplegia or death. The risk of these most catastrophic events is extremely rare.

The evidence-based alternatives to manipulation may include mobilisations, soft tissue treatments, pain education, cognitive behavioural therapy and rehabilitation exercises. Alternatives may also include no treatment, referral to a general practitioner, physiotherapist or osteopath.

I have read and understand the consent to procedures. I consent to treatments and understand that I may withdraw my consent at any time. I understand that I may ask questions or raise concerns at any time.

Date: _____

Patient (or parent/legal guardian) sign or type your name here:

_____