

Examination / Analysis

(Chiropractor to complete)

Palpation findings:

Vitals : BP _____ / _____ mmHg Pulse _____ bpm
 Height _____ m Weight _____ kg BMI _____

Postural Analysis
 Notes: standing

sitting

Range of Motion

Sit Upright

Lumbar

Thoracic

Cervical

TMJ

FROM End Feel Jnt Play

Reflexes:

Biceps (C5)
 Brachioradialis (C6)
 Triceps (C7)

Patellar (L4)
 Achilles (S1)

Abdominal / Babinski / Clonus

Muscle Strength /5

Left	Right
Hip Flex	
Knee Ext	
Knee Flex	
Dorsiflex	
Plantar Flex	
Inversion	
Eversion	
Hallucis Ext	
Hallucis Flex	

Sensory:

Elbow Flex	
Elbow Ext	
Arm Abd	
Arm Add	
Wrist Ext	
Wrist Flex	
Grip strength	
Finger Flex	
Finger Ext	
Finger Abd	
Opposition	

Orthopaedic:

/ standing

SLR	
WLR	
Braggard	
Patrick Fabere	
Internal Hip Rot	
Occ Challenge	
Valsalva	
Soto Hall	

/ seated

L	R
Malgus	
Compression	
Forminal Comp.	
Distraction	
Shoulder Dep.	
Kempas	
Appleys Scratch	
TOS - Allens	
Addisons	
Edens	
Whights	

/ prone

L	R
Neckliss	
Yeomans	
Elvis	
Hibbs	
Sac comp	
Sac ext	

Leg Length Inequality L / R _____ mm + / - Derfeld

Cervical Syndrome C1 C2 C3-7

Planter Flex Burns bench McBride Hoover

Special Tests:

Cranial Nerves:

I II III, IV, VI V VII VIII XI XII

Cerebellar / Posterior Column function:

Rhomburgs Dysdiadochokinesis Proprioception Vibration Sense Fine Touch

Regional exam / Other:

Other Notes:

Analysis / Clinical Impression:

Plan of Management : _____ x _____ wks _____ x _____ wks reassess _____ x _____ wks _____ x _____ wks

Stretches: C/S ROM C/S stretches S/O Traction SHld Rot
 Percutis Cal Psoas/Hip Flexors Kneal to Shw
 Lumbar Xccl Hamstrings Gastro Other

Strengthening: C/S isometrics Traps Abs - upper / lower Superman Other

Other recommendations: _____

Referral: Xray Gal Scan GP Other

DC Signature _____ Date _____

Please answer all questions as best you can and sign the consent at the end of this form.
 Some of the following questions may seem irrelevant to your case. However, they assist us in delivering the safest and best possible care, and many are required by law. All information you give is **private and confidential**.

Personal Details

Full Name: _____ I prefer to be called: _____
 Male Female Date of Birth: _____ Age: _____
 Marital Status: Single Married Number of Children (if any): _____
 Occupation: _____
 Address: _____
 Telephone: Home- _____ Work- _____ Mobile- _____
 Email: _____
 Your Medical Doctor: _____ Consent to contact if required
 How did you hear about our office (e.g. referral from GP, friend, phonebook): _____

Current Health Condition

Have you ever had Chiropractic Care before: Yes No

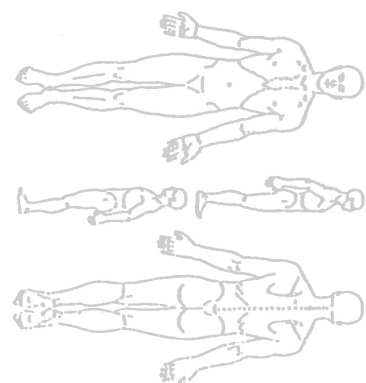
Reason for this appointment (e.g. wellness care, prevention, low back pain, asthma, headaches, posture...)

When did your problem begin (date or number of days, months, or years): _____

How did this problem begin (e.g. accident, lifting, work related, gradual onset...)

Please mark any areas of pain or discomfort on the diagrams and label with the letter that best describes it:

- S = Sharp / Stabbing
- D = Dull / Achy
- P = Pins & Needles
- N = Numbness
- B = Burning
- O = Other



Practitioners seen for this problem (e.g. GP, Physiotherapist...): _____

Does anything make it better (e.g. position, rest, ice...)

Does anything make it worse (e.g. standing, bending, coughing...)

Current medications: Pain Killers Muscle Relaxants Corticosteroids Blood Pressure Pills
Birth Control Vitamins Others List names and dosage if possible: _____

Have you previously been on any long-term medications? Yes No _____

Overall Health Status & Health History

Have you experienced any of the following in the last 12 months ?

NEURO- MUSCULO-SKELETAL

- Low-Back Pain
- Neck Pain
- Pain between Shoulders
- Shoulder Pain
- Arm Pain
- Leg Pain
- Walking Problems
- Stiffness
- Headaches
- Migraines
- Numbness
- Tingling, Burning, or Pins & Needles
- Weakness
- Paralysis
- Dizziness / Vertigo
- Fainting
- Anxiety
- Confusion
- Depression
- Convulsions

GASTRO-INTESTINAL

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Significant Weight Loss
- Significant Weight Gain
- Frequent Nausea
- Vomiting
- Heartburn / Reflux
- Liver Problems
- Gall Bladder Problems
- Bowel Problems (e.g. bleeding, constipation, gas, diarrhoea, cramps)

EARS/EYES/NOSE/THROAT

- Allergies
- Sinus Problems
- Vision Problems
- Dental Problems
- Ear Ache
- Sore Throat
- Hearing Difficulty

GENERAL

- Stress
- Loss of sleep
- Fever
- Chronic / Recurrent Infections

GENITO-URINARY

- Bladder Problems (eg. changes to frequency, volume, control)

- Painful Urination
- Discoloured Urine
- Sexual Dysfunction

- Sexually Transmitted Infection / Disease

- Menstrual Irregularity
- Menstrual Cramping
- Breast Pain / Lumps
- Prostate Problems

FEMALES ONLY

- Are You Pregnant?
- Yes No Unsure

Please tick if you have, **or have ever had**, any of the following conditions:

Cancer Stroke Diabetes Heart Disease Arthritis Osteoporosis

Other (e.g. HIV or AIDS, Hepatitis, Psoriasis, Polio, Epilepsy etc): _____

Have you been treated for any other health condition in the last year? Yes No
If yes, please explain: _____

Surgery / Operations (e.g. Appendix, C-section, Hip-Replacement, Discectomy...)

Significant accidents, injuries, or falls (include major childhood injuries, motor vehicle accidents...): _____

Hospitalisation (other than above): _____

Family history of major illnesses e.g. breast cancer (mother), diabetes (father): _____

Lifestyle Assessment

On a scale of 1 to 10 how do you presently feel? (mark on line below)

1 _____ 10
(worst) (best)

When did you last feel 100%? _____

What activities of daily living are most affected by your current condition (e.g. dressing, sleeping, sport, gardening...): _____

Do you mainly sleep on your: Side Back Stomach

Do you smoke? No Yes: Present / Past How many cigarettes per day? _____

Currently, what are the 3 healthiest activities in your life? (e.g. exercise, meditation, balanced nutrition, good hydration...)

1. _____
2. _____
3. _____

Currently, what are the 3 least healthy activities in your life? (e.g. smoking, poor nutrition or hydration, stress...)

1. _____
2. _____
3. _____

*Chiropractic acknowledges that the body has an innate ability to heal. Chiropractors strive to assist the natural healing response by correcting **subluxations**. Abnormal joint motion and alignment (subluxations) cause nerve interference by irritating or placing pressure on the spinal cord and nerves and altering neuro-biologic integration. The nervous system is vitally important to our wellbeing as it controls and co-ordinates all functions of the body. If the flow of nerve information around the body is disrupted, the healing response is compromised, and many health problems can arise.*

Patient Signature (consent for examination & care): _____ Date: _____

Thank you for filling out this important information.
Enjoy your visit and the many benefits of Chiropractic Care!