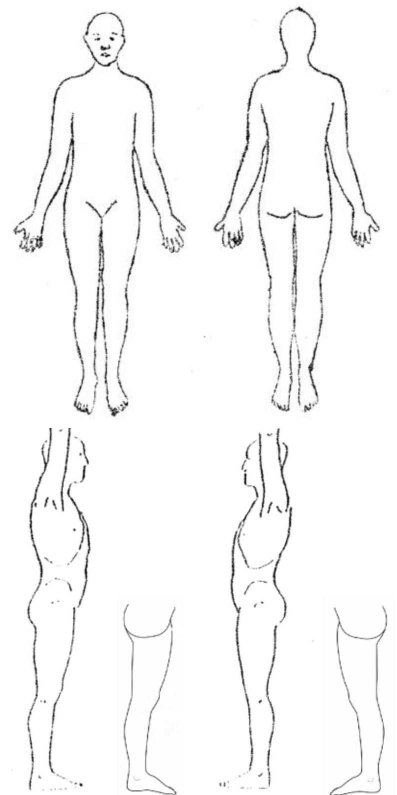
COWIN CHIROPRACTIC CLINIC, Introductory Question Sheet



If you have pain, please indicate your main pain location on the diagram(s) above.

FULL NAME . . . .

Date of Birth . . / . . / . . Weight . . . . Height . . . . . Health Fund. . . . .

Address . . . . Postcode . . . . . .

Ph h) . . . . w) . . . . m). . . . . Fax . . . .

e-mail . . . .

Occupation .Employer. . . . .

Who is your **referrer**/introducer to this clinic? . . . .

Spouse/Partner. . . . . Occupation . . . .

Employer . . . . Children's ages . . . .

Name of your G.P. . . . . Suburb . . . .

1) **WHAT** IS YOUR **MAIN** DISORDER/COMPLAINT?

Your other complaints should be detailed on Page 4.

OFFICE USE

WHEN did it begin? . . . .

HOW did it begin? . . . .

WHAT did you do about it? . . . .

HOW OFTEN does it occur nowadays? . . . .

If it comes and goes, **HOW LONG** does an episode usually last? . . . .

HOW has it most affected you? [Home life, budget, social life, work, energy, confidence, planning, etc. Please give details.] . . . .

. . . .

WHY have you decided to make an appointment here now, as opposed to next week or last week?

(Please tick one or more of the options below)

a) because your condition has worsened lately ☐
b) because you are not improving sufficiently with other forms of health care ☐
c) because you have recently learned of our procedures ☐
d) other ☐ (Please give details) . . . .

. . . .

What influences tend to make your condition **WORSE**?
(such as movements, kinds of activities, times of day, weather, stressful situations, foods etc.)

OFFICE USE

What influences tend to make it **BETTER** or at least more bearable?

VARIATIONS AND SEVERITY

Please tick **three** numbers in the boxes to indicate LEAST troublesome, AVERAGE severity and MOST troublesome in the past two months.

0	1	2	3	4	5	6	7	8	9	10

0 = absent or not noticeable 10 = maximum pain or distress

NECK FACTORS IN WORK, STUDY, LEISURE AND SPORT

What NECK OR OTHER INJURY (bumped head, motor vehicle accident, jerky movement, fall, etc.) may have happened shortly before your complaint began?

DISTANT HISTORY of trauma (difficult or violent birth, prolonged labour, childhood and later accidents, falls, injuries).

What NECK STRAIN (falling asleep when sitting, reading in bed, working in awkward position such as painting or working under house or car, etc.) may have happened shortly before your complaint began?

What NECK TIREDNESS (reading, sewing, computer operation, etc,) may have happened shortly before your complaint began?

OFFICE USE

TESTS DONE (Please tick)
X-ray: head ☐, neck ☐, back ☐, other X-rays ☐, CT ☐ MRI ☐

Ultrasound ☐ Blood ☐ Hearing tests ☐ ECochG ☐ Balance ☐

Other ☐ (please give details) . . . .

Health professionals currently or recently managing your disorder/complaint.
(GP, specialist, masseur, naturopath, physio., etc)

1. name profession suburb

______________________ ____________________ ______________________

diagnosis________________________ **prognosis**__________________________
(i.e., what did he/she tell you was wrong?) (i.e., what did he/she tell you to expect?)

2. name profession suburb

______________________ ____________________ ______________________

diagnosis________________________ **prognosis**__________________________
(i.e., what did he/she tell you was wrong?) (i.e., what did he/she tell you to expect?)

3. name profession suburb

______________________ ____________________ ______________________

diagnosis________________________ **prognosis**__________________________
(i.e., what did he/she tell you was wrong?) (i.e., what did he/she tell you to expect?)

4. name profession suburb

______________________ ____________________ ______________________

diagnosis________________________ **prognosis**__________________________
(i.e., what did he/she tell you was wrong?) (i.e., what did he/she tell you to expect?)

treatment(s), **operation(s)**, etc.____

medications: drug name	dose	frequency	beginning date	till what date

OUTCOMES (i.e., results of the above treatments, operations and medications)

____
____
____

Other things you think we should know about your main disorder/complaint.

____
____
____
____

2) WHAT IS YOUR NEXT MOST-IMPORTANT DISORDER/COMPLAINT?

. . . .

WHEN did it begin? . . . .

HOW did it begin? . . . .

WHAT did you do about it? . . . .

HOW OFTEN does it occur? . . . .

HOW does it most affect you? . . . .

Please tick **three** numbers in the boxes to indicate LEAST troublesome, AVERAGE severity and MOST troublesome in the past two months.

0	1	2	3	4	5	6	7	8	9	10

0 = absent or not noticeable 10 = maximum pain or distress

Main health professional currently or most recently managing your disorder/complaint. (GP, specialist, masseur, naturopath, physio., etc)

name ____

profession or specialty ____________________ suburb ____________________

diagnosis ____________________ **prognosis** ____________________
(i.e., what did he/she tell you was wrong?) (i.e., what did he/she tell you to expect?)

treatment(s), operation(s), medications, etc. ____________________

____

OUTCOMES (i.e., results of the above treatments, operations and medications)

____

____

If you have pain, please indicate your main pain location on the diagram(s) above.

OFFICE USE

3) OTHER DISORDERS/COMPLAINTS

Please use the boxes to write in what **age** you were when the problem **began** and cross out areas which are not a problem, e.g., if you have ear problems which began at about 15 years of age but no nose or throat problems, indicate as: [15] Ears, ~~Nose, Throat~~

AGE		AGE		AGE		AGE	
☐	Cancer, Diabetes	☐	Legs, Feet	☐	Sinusitis, Allergy	☐	Bowels, Bladder
☐	Heart, Stroke	☐	Ears, Nose, Throat	☐	Eyes	☐	Periods, Prostate
☐	Headaches	☐	Asthma	☐	Irritability, Worry, Depression	☐	Eating
☐	Neck, Shoulders	☐	Jaw, Face	☐	Sleeping	☐	Other…………..
☐	Arms, Hands	☐	Stiffness	☐	Shortness of Breath	☐	
☐	Back, Hips	☐	Dizziness, Co-ordination	☐	Tiredness	☐	

. . . .

SIGNED ______________________________ DATE ______________________