Patient Registration Form

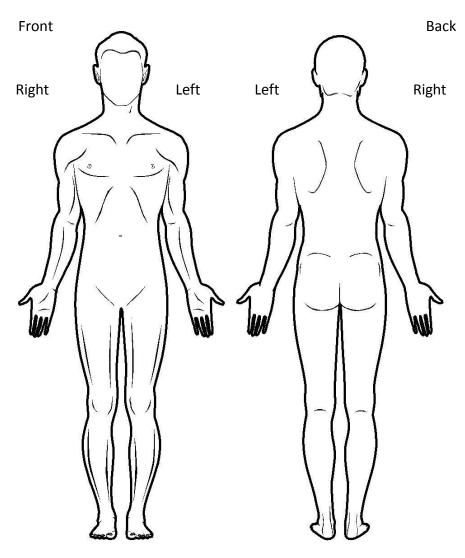


DO YOU GIVE CONSENT FOR YOUR INFORMATION TO BE COPIED TO OTHER MEDICAL SPECIALISTS ASSISTING IN YOUR CARE Y / N

Family Name:							
	Family Name: Fi			Middle Name:			
Full Name Of Parent(s) If Patient l	Jnder 16	5:				
Address:				Suburb:			
Post Code:			Email:				
Home Phone:			Work Phone:	Mobile:	Mobile:		
Gender:	Age:		Date Of Birth:	Height:	Weight:		
BMI:	Handedn	ess:					
Emergency Contact:							
Next of Kin (Full Name	e):			Relationship:			
Mobile:			Work Phone:				
Private Health Insurar	nce: Yes	No	Health Fund Name:	Membership N	umber:		
Aged/Disability Pension	on: Yes	No	Membership Number:		Expiry:		
Medicare Number:			Position on C	Card:	Expiry:		
General Practitioners	Name:						
General Practitioners	Address:						
			and Compulsory 1				
Workers Col (Please note that if yo your appointment otl	mpensou are comin	atior		Third Party ovide approval for your con	-		
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Workers Col (Please note that if your appointment other sorry for any inconverting the sorry	mpensou are cominerwise you nience). plicable):	atior ng in und will be	and Compulsory Term and Compulsory Term and Compulsory Term and once the full amount and once th	Third Party ovide approval for your concerning you receive approval your Date of Injury: Phone: Type:	may claim back through insurance		
Workers Col (Please note that if your appointment otl Sorry for any inconve Employer Name (if ap Employers Address: Solicitors Name & Add Claim Number: Telephone: Location of injury: Chief Complaints: Neck Pain:	mpensou are cominence). plicable):	atior ng in und will be licable):	and Compulsory To and Compulsory To and Compulsory To and to procharged the full amount and once	Third Party ovide approval for your consequence of proval your consequence of Injury: Date of Injury: Phone: Type: Type:	may claim back through insurance		
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Place correct markings indicating your pain.

Pain: XXXX Numbness: OOOO



Circle your pain levels over the past two weeks:

Back Pain: Leg Pain:

(None) 1-2-3-4-5-6-7-8-9-10 (None) 1-2-3-4-5-6-7-8-9-10

Neck Pain: Arm Pain:

(None) 1-2-3-4-5-6-7-8-9-10 (None) 1-2-3-4-5-6-7-8-9-10

Describe your pain (Circle ALL that applies to you)

Constant Deep Dull Sharp Intermittent Throbbing
Stiffness Aching Shooting Cramp Burning Stabbing

When is your pain at its worst:

Walking Standing Sitting Lying Down

What relieves it:

Walking Standing Sitting Lying Down

Physiotherapy: Better Worse No Change Acupuncture: Better Worse No Change Medication: Better Worse No Change Acupuncture: Better Worse No Change Chiropractic Adjustment: Better Worse No Change Spine Injections: Better Worse No Change Bed rest: Better Worse No Change Pool Therapy: Better Worse No Change JE you have had previous spinal surgery, what were your symptoms before the surgery? Please describe: Did your symptoms improve after surgery? If yes show long afterwards? JE you have had previous spinal surgery? If yes spalani: Have you been released back to work after surgery? If yes explain: Have you been released back to work after surgery? If yes when? Medical History: If you have ever had (circle all that apply) Asthma/Breathing difficulties Phiebitis or blood clots Cancer Strokes Radiation/Chemotherapy Thyroid trouble(s) Migraine/Other Severe Headaches Radiation/Chemotherapy Diabetes Heart Attack AIDS/HIV Diabetes Heart Attack AIDS/HIV Diabetes Heart Attack Seizures Bone Mineral Density Scan: Previous Investigations: Previous Investigations: Please list the dates you have had the following Radiology studies: MRI: Bone Mineral Density Scan: EMG/Nerve Conduction Studies; MRI: Bone Mineral Density Scan: _	Previous Treatment (Circle if	you have	had this treatme	ent then indicate if it w	as better	, worse	or made no change)
Chiropractic Adjustment Better Worse No Change Spine Injections: Better Worse No Change Bed rest: Better Worse No Change Pool Therapy: Better Worse No Change IF you have had previous spinal surgery, what were your symptoms before the surgery? Please describe: Did your symptoms improve after surgery? If yes how long afterwards? If yes when? Did your symptoms get worse after surgery? If yes explain: If yes when? Medical History: If you have ever had (circle all that apply) Asthma/Breathing difficulties Philebitis or blood clots Cancer Strokes Radiation/Chemotherapy Thyroid trouble(s) Migraine/Other Severe Headaches Kidney Infections High Blood Pressur Heart Attack AIDS/HIV Diabetes Stomach Ulcers Seizures Tuberculosis Therefore the dates you have had the following Radiology studies: Previous Investigations: Previous Investigations: Previous Investigations: Bone Mineral Density Scan: EMG/Nerve Conduction Studies: ***Trays: Bone Scan: ***Date (If known) Date (If known)	Physiotherapy:	Better	Worse	No Change	Massage:	Better	Worse	No Change
Better Worse No Change Pool Therapy: Better Worse No Change If you have had previous spinal surgery, what were your symptoms before the surgery? Please describe:	Medication:	Better	Worse	No Change	Acupuncture:	Better	Worse	No Change
If yes how long afterwards?	Chiropractic Adjustment:	Better	Worse	No Change	Spine Injections:	Better	Worse	No Change
Did your symptoms improve after surgery? If yes how long afterwards? Did your symptoms get worse after surgery? If yes explain: Hyes explain: If yes when? If yes when? If yes when?	Bed rest:	Better	Worse	No Change	Pool Therapy:	Better	Worse	No Change
Did your symptoms get worse after surgery?	IF you have had prev	ious spi	nal surge	ery, what were yo	our symptoms before t	he surger	y? Pleas	e describe:
Medical History: If you have ever had (circle all that apply) Asthma/Breathing difficulties	Did your symptoms improv	ve after sı	urgery?		If yes how long afterw	ards?		
Medical History: If you have ever had (circle all that apply) Asthma/Breathing difficulties	Did your symptoms get wo	rse after	surgery ?		If yes explain:			
Asthma/Breathing difficulties Phlebitis or blood clots Cancer Strokes Radiation/Chemotherapy Thyroid trouble(s) Migraine/Other Severe Headaches Kidney Infections High Blood Pressur Heart Attack AIDS/HIV Diabetes Kidney Stone Fibromyalgia Arthritis Stomach Ulcers Seizures Tuberculosis Hepatitis Other: Previous Investigations: Please list the dates you have had the following Radiology studies: MRI: CT Scan: CT Scan: Bone Mineral Density Scan: EMG/Nerve Conduction Studies: X-rays: Bone Scan: Medication Allergies: Name Of Medication Type Of Reaction Date (If known)	Have you been released ba	ack to wo	rk after su	rgery ?	If yes when ?			
Please list the dates you have had the following Radiology studies: MRI: Bone Mineral Density Scan: CT Scan: EMG/Nerve Conduction Studies: X-rays: Bone Scan: Medication Allergies: Name Of Medication Type Of Reaction Date (If known)	Asthma/Breathing difficult Strokes Migraine/Other Severe He Heart Attack Kidney Stone Stomach Ulcers Hepatitis	ies	ever had	Phlebitis or I Radiation/Ch Kidney Infect AIDS/HIV Fibromyalgia	blood clots nemotherapy tions		Th Hig Dia Arti	yroid trouble(s) h Blood Pressure betes hritis
Name Of Medication Type Of Reaction Date (If known)	Please list the dates you ha	ave had th			EMG/Nerve Conduct	ion Studies	:	
	Medication Allergies:							
	Name Of Medication			Type Of Read	ction		Dat	te (If known)

Current Medications:

Please list the medications you currently take including prescription, non-prescription, vitamins and supplements

Na	ame	Dose Frequer	су	Na	ame	Dose	Frequency
1				8			
2.							
-							
<u> </u>				13.			
7				14			
Family	History:						
	inyone in your far hat apply to you:	nily apart from you	suffer from any	of the followi	ng conditions? I	Please circle	and describe
Spinal Pr	oblems	Please Descr	ibe:				
Bleeding	Disorders	Please Descr	ibe:				
Heart Di	sease	Please Descr	ibe:				
Cancer		Please Descri	be:				
Diabetes Please Describe:							
Social I	History:						
Marital S	Status: Single	Married	De Facto	Divorced	Widowed	Separato	ed
Number	of children (if any): _	Age(s): _			_		
Who Live	es with you at home?	:					
Work sta	ntus: Working	Not Working	Homemaker	Student	Disabled	Retired	
Primary	occupation (Or previc	ous if not currently work	ing/retired):				
Have you	u ever/ do you curren	tly use tobacco? If yes h	ow many a day:		Years Smoking:		
Date cea	sed:						
Amount	of alcohol consumed	in a typical week:					
Do you u	ise recreational drugs	?					
Do you p	participate in regular e	exercise? (If yes please d	escribe)				