



Integrated Health Care

Ph (03) 332 0743

www.integratedhealth.co.nz

149 Barrington St, Somerfield, Christchurch, 8024

Registered Chiropractors and Applied Kinesiologists

CONFIDENTIAL CASE HISTORY

PLEASE ANSWER ALL QUESTIONS AS ANY INFORMATION IS IMPORTANT FOR US TO KNOW

NAME: EMAIL

ADDRESS: TOWN:

PHONE (home): PHONE (mobile): PHONE (work):

DATE OF BIRTH:/...../..... AGE: No. of CHILDREN:

OCCUPATION: REFERRED BY:

PLEASE PRINT

What is your major complaint?
.....
.....

When did this present complaint start?weeksmonthsyears

Has this occurred previously? When did the first occurrence start?

Is your complaint:continuous?off & onneither

How did this complaint occur?graduallysuddenlyfrom an injuryat work

What was the cause of the complaint?

Have you sought treatment for this complaint? If so, who?

How successful was previous treatment?

Please list other significant complaints

Please indicate anything that aggravates your complaint

Please indicate anything that alleviates your complaint

Please list any test you have had regarding your health (x-rays, blood tests etc)

If you have physical pain: 1. Is it worse with:sneeze/coughsittingbendingwalkinglying

.....drivingwhen I awakeat nightduring the night

2. Is there any radiation of pain? if so, where?

3. Have you had previous spinal/extremity complaints?When?

Please list any motor vehicle or personal accidents you have had, when they occurred and the injuries associated with them (including sporting injuries)

Please list all surgical operations you have had, where they occurred and when

Please indicate all medication you are taking at present:sleeping pillspain killersmuscle relaxantsblood pressuretranquillizersinsulinbirth controlasthma medicationanti-inflammatories others.....

Please list all blood tests completed (include results):

Have you ever had any emotional/mental disorders? When? Describe briefly

Have you received treatment from a Chiropractor before? who and when?

Dental visits:6 monthlyyearlytoothache or emergencycomplete denturespartial dentures -If you have dentures, how old are the current set?

Do you wear arch supports, orthotics etc? who fitted them and when

Have you ever had cancer? If yes, when did it occur? Type of cancer

Does your pain wake you from a sound sleep? Is this the same time every night? when?

Are you losing weight now without trying?

Are you coughing up blood or do you notice blood in your stool or urine?

Have you had any loss of bowel or bladder control?

Have you lost consciousness or had double vision recently?

Are you seeing any other doctor now for any reason?

Is there a chance that you are pregnant now?

HAVE YOU EVER: (answer yes or no)

Describe briefly

Been knocked unconscious?
Been hospitalized other than surgery?
Used a cane, crutch or other support?
Been treated for a spine/nerve disorder?
Had a fractured bone?

DO YOU:

Take vitamins, minerals or herbs?
Have an allergy to any drug?

HABITS:

Alcohol - heavy / moderate / light / none Tobacco - no. of cigarettes per day
Sleep - number of hours Is your sleep - sound / light / wake often / unrefreshing
Exercise - Drugs -
Is there anything else we should know?

Have you ever received ACC for any personal injury? If so, when?

- What was the nature of the injury?

Is this an ACC related complaint?

Integrated Health Care produces a quarterly newsletter. Would you like to receive a copy by email? **Yes/ No** (circle)

ADDITIONAL HEALTH QUESTIONNAIRE

Have you ever suffered from any of the following. Tick the left box for symptoms and conditions you have experienced and the right for symptoms and conditions you suffer from now.

		past	now			past	now			past	now
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	convulsion	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>		
	fainting	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	fever	<input type="checkbox"/>	<input type="checkbox"/>		
	poor sleep	<input type="checkbox"/>	<input type="checkbox"/>	loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>		
	anxiety	<input type="checkbox"/>	<input type="checkbox"/>	sweats	<input type="checkbox"/>	<input type="checkbox"/>	tremors	<input type="checkbox"/>	<input type="checkbox"/>		
HEAD/NECK	thyroid	<input type="checkbox"/>	<input type="checkbox"/>	goitre	<input type="checkbox"/>	<input type="checkbox"/>	enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>		
	eye pain	<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	eyesight	<input type="checkbox"/>	<input type="checkbox"/>		
	ear noises	<input type="checkbox"/>	<input type="checkbox"/>	skin problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
STRUCTURAL	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	bursitis	<input type="checkbox"/>	<input type="checkbox"/>	foot trouble	<input type="checkbox"/>	<input type="checkbox"/>		
	low back pain	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	neck pain	<input type="checkbox"/>	<input type="checkbox"/>		
	upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	sciatica	<input type="checkbox"/>	<input type="checkbox"/>		
	swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	poor posture	<input type="checkbox"/>	<input type="checkbox"/>	hernia	<input type="checkbox"/>	<input type="checkbox"/>		
pain or numbness in											
	elbows	<input type="checkbox"/>	<input type="checkbox"/>	hands	<input type="checkbox"/>	<input type="checkbox"/>	hips	<input type="checkbox"/>	<input type="checkbox"/>		
	legs	<input type="checkbox"/>	<input type="checkbox"/>	knees	<input type="checkbox"/>	<input type="checkbox"/>	feet	<input type="checkbox"/>	<input type="checkbox"/>		
RESPIRATORY	asthma	<input type="checkbox"/>	<input type="checkbox"/>	colds	<input type="checkbox"/>	<input type="checkbox"/>	earache	<input type="checkbox"/>	<input type="checkbox"/>		
	nasal problems	<input type="checkbox"/>	<input type="checkbox"/>	sinus	<input type="checkbox"/>	<input type="checkbox"/>	tonsils/throat	<input type="checkbox"/>	<input type="checkbox"/>		
	cough	<input type="checkbox"/>	<input type="checkbox"/>	wheeze	<input type="checkbox"/>	<input type="checkbox"/>	lung problems	<input type="checkbox"/>	<input type="checkbox"/>		
	breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>								
GASTHO- INTESTINAL	gas/wind	<input type="checkbox"/>	<input type="checkbox"/>	bloating	<input type="checkbox"/>	<input type="checkbox"/>	colitis	<input type="checkbox"/>	<input type="checkbox"/>		
	constipation	<input type="checkbox"/>	<input type="checkbox"/>	diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>		
	hunger	<input type="checkbox"/>	<input type="checkbox"/>	gall-bladder	<input type="checkbox"/>	<input type="checkbox"/>	haemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		
	jaundice	<input type="checkbox"/>	<input type="checkbox"/>	liver	<input type="checkbox"/>	<input type="checkbox"/>	nausea	<input type="checkbox"/>	<input type="checkbox"/>		
	stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	vomiting	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>		
CARDIO- VASCULAR	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	heart pain	<input type="checkbox"/>	<input type="checkbox"/>		
	rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>		
	hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
GENITO- UHINARY	bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	infections	<input type="checkbox"/>	<input type="checkbox"/>	kidney/bladder stones	<input type="checkbox"/>	<input type="checkbox"/>		
	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	incontinence	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>		
	prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	pus in urine	<input type="checkbox"/>	<input type="checkbox"/>					
WOMEN ONLY	cramps/backache	<input type="checkbox"/>	<input type="checkbox"/>	excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	hot flushes	<input type="checkbox"/>	<input type="checkbox"/>		
	irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	menopause	<input type="checkbox"/>	<input type="checkbox"/>		
	menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>	thrush	<input type="checkbox"/>	<input type="checkbox"/>	pre-menstrual tension	<input type="checkbox"/>	<input type="checkbox"/>		
SKIN	acne	<input type="checkbox"/>	<input type="checkbox"/>	eczema	<input type="checkbox"/>	<input type="checkbox"/>	dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		
	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	allergic rashes	<input type="checkbox"/>	<input type="checkbox"/>		
	cold sores	<input type="checkbox"/>	<input type="checkbox"/>	mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>		
ALLERGIES	hives	<input type="checkbox"/>	<input type="checkbox"/>	sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	iritis	<input type="checkbox"/>	<input type="checkbox"/>		
	asthma	<input type="checkbox"/>	<input type="checkbox"/>	hayfever	<input type="checkbox"/>	<input type="checkbox"/>	foods	<input type="checkbox"/>	<input type="checkbox"/>		
	skin	<input type="checkbox"/>	<input type="checkbox"/>	itchiness	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>		
	athletes foot	<input type="checkbox"/>	<input type="checkbox"/>	allergies to animals, dust, pollens, flowers etc.				<input type="checkbox"/>	<input type="checkbox"/>		

Please tick the following conditions you have had:

anaemia	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	cancer	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	diphtheria	<input type="checkbox"/>	emphysema	<input type="checkbox"/>
epilepsy	<input type="checkbox"/>	goitre	<input type="checkbox"/>	gout	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	malaria	<input type="checkbox"/>	measles	<input type="checkbox"/>
miscarriage	<input type="checkbox"/>	mumps	<input type="checkbox"/>	pleurisy	<input type="checkbox"/>	pneumonia	<input type="checkbox"/>	polio	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>
stroke	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	ulcers	<input type="checkbox"/>	chicken pox	<input type="checkbox"/>	scarlet fever	<input type="checkbox"/>	rheumatic fever	<input type="checkbox"/>

The above information is to the best of my knowledge correct and I have not omitted anything about my health.

Signed Date/...../.....

AUTHORISATION FOR CARE

I give my informed consent and authorize the Chiropractor's of Integrated Health Care, to administer Chiropractic care, the Hale Technique and Homeopathy as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by Integrated Health Care on the day of service. I acknowledge that I have access to my information as per the Privacy Act and that all information supplied is private and confidential.

Printed Name

Signature

Date