Integrated Health Care

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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? .....weeks .....months .....years

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

Is your complaint: .....continuous? .....off & on .....neither

How did this complaint occur? .....gradually .....suddenly .....from an injury .....at 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/cough .....sitting .....bending .....walking .....lying .....driving .....when I awake .....at night .....during 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 pills .....pain killers .....muscle relaxants .....blood pressure .....tranquillizers .....insulin .....birth control .....asthma medication .....anti-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 monthly .....yearly .....toothache or emergency .....complete dentures .....partial 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	☐	☐	convulsion	☐	☐	dizziness	☐	☐
	fainting	☐	☐	fatigue	☐	☐	fever	☐	☐
	poor sleep	☐	☐	loss of weight	☐	☐	depression	☐	☐
	anxiety	☐	☐	sweats	☐	☐	tremors	☐	☐
HEAD/NECK	thyroid	☐	☐	goitre	☐	☐	enlarged glands	☐	☐
	eye pain	☐	☐	nose bleeds	☐	☐	eyesight	☐	☐
	ear noises	☐	☐	skin problems	☐	☐			
								☐	☐
STRUCTURAL	arthritis	☐	☐	bursitis	☐	☐	foot trouble	☐	☐
	low back pain	☐	☐	chest pain	☐	☐	neck pain	☐	☐
	upper back pain	☐	☐	headaches	☐	☐	sciatica	☐	☐
	swollen joints	☐	☐	poor posture	☐	☐	hernia	☐	☐
pain or numbness in									☐
	elbows	☐	☐	hands	☐	☐	hips	☐	☐
	legs	☐	☐	knees	☐	☐	feet	☐	☐
RESPIRATORY	asthma	☐	☐	colds	☐	☐	earache	☐	☐
	nasal problems	☐	☐	sinus	☐	☐	tonsils/throat	☐	☐
	cough	☐	☐	wheeze	☐	☐	lung problems	☐	☐
	breathing difficulties	☐	☐						
GASTHO-INTESTINAL	gas/wind	☐	☐	bloating	☐	☐	colitis	☐	☐
	constipation	☐	☐	diarrhoea	☐	☐	difficult digestion	☐	☐
	hunger	☐	☐	gall-bladder	☐	☐	haemorrhoids	☐	☐
	jaundice	☐	☐	liver	☐	☐	nausea	☐	☐
	stomach pain	☐	☐	vomiting	☐	☐	indigestion	☐	☐
CARDIO-VASCULAR	high blood pressure	☐	☐	low blood pressure	☐	☐	heart pain	☐	☐
	rapid heart beat	☐	☐	varicose veins	☐	☐	swollen ankles	☐	☐
	hardening of arteries	☐	☐	bruise easily	☐	☐	poor circulation	☐	☐
		☐	☐		☐	☐		☐	☐
GENITO-UHINARY	bedwetting	☐	☐	infections	☐	☐	kidney/bladder stones	☐	☐
	frequent urination	☐	☐	incontinence	☐	☐	painful urination	☐	☐
	prostate trouble	☐	☐	pus in urine	☐	☐			
WOMEN ONLY	cramps/backache	☐	☐	excessive flow	☐	☐	hot flushes	☐	☐
	irregular cycle	☐	☐	lumps in breast	☐	☐	menopause	☐	☐
	menstrual pain	☐	☐	thrush	☐	☐	pre-menstrual tension	☐	☐
SKIN	acne	☐	☐	eczema	☐	☐	dermatitis	☐	☐
	psoriasis	☐	☐	hives	☐	☐	allergic rashes	☐	☐
	cold sores	☐	☐	mouth ulcers	☐	☐	other	☐	☐
ALLERGIES	hives	☐	☐	sinusitis	☐	☐	iritis	☐	☐
	asthma	☐	☐	hayfever	☐	☐	foods	☐	☐
	skin	☐	☐	itchiness	☐	☐	other	☐	☐
	athletes foot	☐	☐	allergies to animals, dust, pollens, flowers etc.				☐	☐

Please tick the following conditions you have had:

anaemia	☐	arthritis	☐	cancer	☐	diabetes	☐	diphtheria	☐	emphysema	☐
epilepsy	☐	goitre	☐	gout	☐	heart disease	☐	malaria	☐	measles	☐
miscarriage	☐	mumps	☐	pleurisy	☐	pneumonia	☐	polio	☐	multiple sclerosis	☐
stroke	☐	tuberculosis	☐	ulcers	☐	chicken pox	☐	scarlet fever	☐	rheumatic fever	☐

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