PATIENT PERSONAL DETAILS

Chiropractic Centre | New Zealand College of Chiropractic

The Chiropractic Centre is the training facility of the New Zealand College of Chiropractic.

You will be assessed and cared for by interns under the supervision of a registered chiropractor.

Personal Information

Name: _____
First *Last* *Preferred name*

Date of birth: ___/___/_____ Age: _____ Sex: ❑ Female ❑ Male ❑ Other options

Address: _____
Street *Suburb* *City*

Phone: _____ E-mail: _____
Home *Mob/Alternate*

We would like to know more about you

Marital status: _____ Ethnicity/culture: _____

Occupation: _____ Native language: _____

Hobbies: _____

Physical activities: _____

Next of Kin / Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone number: *(BH)* _____

_____ *(AH)* _____

Treating GP

Name: _____ Address: _____

Phone: _____ _____

Date & reason of last visit: _____

Chiropractic Care

How did you hear about us?

❑ Website ❑ Chiropractor: _____

❑ Signage ❑ NZCC employee

❑ Chiropractic Centre patient ❑ Specific Event: _____

❑ Contact with a specific NZCC intern or student, name: _____

Is your presenting complaint a result of an accident or injury? ❑ No ❑ Yes

Have you previously received chiropractic care? ❑ No ❑ Yes

Reason for care: _____

Date of last visit: ___/___/_____ Were spinal x-rays taken? ❑ No ❑ Yes, date: ___/___/_____

Name of previous chiropractor/NZCC intern*: _____

CONSENT FOR CARE AND SHARE OF INFORMATION

Chiropractic care will not commence until this page has been completed.

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New Zealand College of Chiropractic is an educational institution. At times, patient files may need to be discussed between Chiropractic Centre Mentors and Interns to ensure that you receive optimum care. Year 1 and Year 2 Chiropractic Students are required to observe so may be present during your visit.

From time to time the College takes photographs of staff, mentors, patients and students to record activities within the College. These photos will be used responsibly and measures will be taken to avoid personal identification. Please advise the College if you have any concerns about publication of your photos.

Video assessments may be used for the purposes of teaching and ongoing training. Videos are not made public, and patients are not identified.

Data collection may take place through student evaluations, patient feedback, and patient records for research purposes. Individuals will not be identified. This research may be published and held by the College in perpetuity. The supply of the information is voluntary except where required for funding and/or government reporting purposes.

I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent for Care and Share of Information above.

Patient Signature: _____ Date: ___/___/___
Custodial parent or legal guardian if patient is a minor

Relationship to patient (if minor): _____

Witness by: _____ Date: ___/___/___

Intern Signature: _____ Date: ___/___/___

Mentor Signature: _____ Date: ___/___/___

Consent to Request Information

In order to obtain a complete health history, it may be necessary for my attending intern to request information from other health care professionals or previous chiropractor.

I, _____ , do hereby provide authorisation for this to take place.
Please print full name

Patient Signature: _____ Date: ___/___/___
Custodial parent or legal guardian if patient is a minor

Intern: _____

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Patient: _____ Date: _____

HEALTH HISTORY

People consult our Chiropractic Centre with varied health objectives. Please indicate below with a "tick" which apply to you.

- ❑ Relief of symptoms
- ❑ Correction of my underlying problem
- ❑ Better perform work or recreational activities
- ❑ Improve my health and enhance my quality of life
- ❑ Maximise my own, my family's and my community's health

Is your appointment today as a result of a recent accident or injury? Yes / No

Please specify your main area of concern:

_____

_____

_____

_____

Please specify any other health problems:

_____

_____

_____

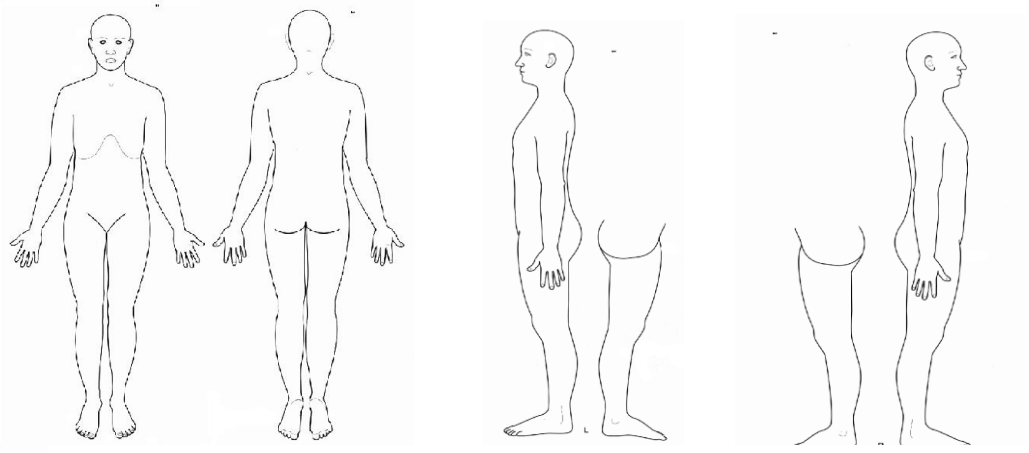
Please state whether there are certain activities you would like assistance improving:

_____

_____

If you experience **pain, numbness or tingling**, please mark the areas on diagrams with:

P for pain and give it a mark from 1 – 10 *(1 being slight and 10 being unbearable pain)*
N for numbness and **T** for tingling



FRONT BACK LEFT RIGHT

Intern initials: _____ Mentor initials: _____

Intern: _____

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Patient: _____ Date: _____

Please circle each individual answer and provide additional information when indicated.
Include both ***past*** and ***present*** conditions.

Please return the completed form to the front desk when you are finished.

Family History

001: Y N High blood pressure
002: Y N Heart disease, type: _____
003: Y N Stroke
004: Y N Cancer, type: _____
005: Y N Musculoskeletal disease, type:_____
006: Y N Other family illness history:
_____
_____

Patient's Current General History

007: Y N Recent weight change ↑ or ↓
008: Y N On-going fever / chills
009: Y N Periodic unexplained sweats
010: Y N Re-occurring allergies
011: Y N Anaemia
012: Y N Bleeding / bruising
013: Y N Malaise / fatigue / weakness
014: Y N Immuno-deficient condition
015: Y N Cancer

Endocrine History

016: Y N Heat / cold intolerance
017: Y N Thyroid conditions
018: Y N Diabetes

Eye / Ear / Nose / Throat

019: Y N Corrective lenses
020: Y N Eye redness, swelling, tearing, pain or itching
021: Y N Other visual conditions
022: Y N Difficulty hearing / deafness / ringing in ears
023: Y N Ear growths / discharge / pain
024: Y N Change in ability to smell or taste
025: Y N Nose growths / discharge / bleeding / pain
026: Y N Sinus conditions
027: Y N Hoarseness
028: Y N Difficulty chewing or swallowing
029: Y N Enlarged / painful glands
030: Y N Growths / lesions in mouth or throat

Gastrointestinal System

031: Y N Change in appetite
032: Y N Food intolerance
033: Y N Nausea / vomiting
034: Y N Indigestion / heartburn / excessive belching / gas
035: Y N Abdominal pain or swelling
036: Y N Change in bowel habits or stool (colour, consistency etc.)
037: Y N Hernia
038: Y N Haemorrhoids
039: Y N Gallbladder / liver / pancreas disease
040: Y N Liver disease

Respiratory System

041: Y N Difficulty breathing / wheezing / asthma
042: Y N Coughing / sneezing
043: Y N Tuberculosis / TB exposure
Date: _____
044: Y N Respiratory infections / pneumonia
045: Y N Exposure to dangerous fumes, toxic chemicals or excessive pollution
Date & type: _____

Cardiovascular System

046: Y N Chest discomfort / pain
047: Y N Palpitations
048: Y N Swelling / oedema
049: Y N Cold hand / feet
050: Y N Fainting
051: Y N High blood pressure
052: Y N Heart disease (past / current)
053: Y N Rheumatic fever

Urinary System

054: Y N Frequent urination
055: Y N Increased thirst
056: Y N Urinary urgency / pain / hesitancy / discharge / dribbling
057: Y N Urinary tract infections
058: Y N Kidney disease / stones
059: Y N Flank (side) / pelvic pain

Intern initials: _____ Mentor initials: _____

Intern: _____

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Patient: _____ Date: _____

Skin / Hair / Nails

060: Y N Change in skin texture / colouration
061: Y N Mole changes
062: Y N Change in hair / finger or toe nails

Breasts (Male and Female)

063: Y N Breast lumps / mass / growths / pain / tenderness / dimples
064: Y N Nipple discharge / bleeding

Reproductive System

(Male only)

065: Y N Erectile dysfunction

(Female only)

066: Y N Heavy / painful / irregular periods
067: Y N Menopause
068: Y N Diagnosed reproductive conditions
069: Y N Are you currently pregnant?
070: Y N Fertility issues

Neurological System

071: Y N Headaches
072: Y N Seizures / epilepsy / involuntary twitches
073: Y N Dizziness / fainting
074: Y N Numbness / tingling
075: Y N Limb weakness
076: Y N Head trauma / concussion
077: Y N Stroke
078: Y N Disc injury
079: Y N Other neurological conditions

Musculoskeletal System

080: Y N Joint stiffness / pain / swelling
081: Y N Muscle cramps
082: Y N Neck pain
083: Y N Upper back pain / mid back pain
084: Y N Low back pain
085: Y N Buttock / groin pain
086: Y N Upper limb condition
087: Y N Lower limb condition
088: Y N Fractures / dislocation / sprains
089: Y N Other injuries – include auto accidents (even minor ones), sports injuries and work-related accidents
090: Y N Other musculoskeletal conditions:
Type: _____

Hospital / Surgery / Medications

091: Y N Implants / supports (including heel lifts)
092: Y N Cardiac (pacemaker, etc.)
093: Y N Have you had any other hospitalisation or surgery?
094: Y N Current prescribed medications

Medication Reason

_____
_____
_____

095: Y N Non-prescribed medications or drugs (including over-the-counter or recreational)

Medication Reason

_____
_____

Psychological History

096: Y N Anxiety
097: Y N Depression
098: Y N Hospitalization for psychological care
099: Y N Other psychological conditions:
_____

100: Over the last 2 weeks how often have you been bothered by the following problems:

100.1 Feeling nervous, anxious or on edge
❑*Nil* ❑*Some days* ❑*½ the week* ❑*Most of the week*

100.2 Not being able to stop or control worrying
❑*Nil* ❑*Some days* ❑*½ the week* ❑*Most of the week*

100.3 Little interest or pleasure in doing things
❑*Nil* ❑*Some days* ❑*½ the week* ❑*Most of the week*

100.4 Feeling down, depressed, or hopeless
❑*Nil* ❑*Some days* ❑*½ the week* ❑*Most of the week*

Lifestyle

101: Y N Do you eat a healthy diet?
102: Y N Have an unusual appetite?
❑ large ❑ small
103: Y N Consume caffeine?
Frequency _____/day or week
104: Y N Consume alcohol?
Frequency _____/day or week
105: Y N Consume water?
Frequency _____/day
106: Y N Eat junk food frequently?

Intern initials: _____ Mentor initials: _____

Intern: _____

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Patient: _____ Date: _____

107: Y N Exercise / sports activity
Frequency _____ /day or week

108: Y N Smoker? past / present

109: Y N Hobbies: _____

Other

110: Y N Is there anything else you think we need to know about you?

_____

_____

_____

I have reviewed and certify that all the information that I have reported above, is true to the best of my knowledge.

_____

Patient Signature Date

HISTORY REVIEW

Intern Name: _____

_____

Intern Signature Date

Mentor Name: _____

_____

Mentor Signature Date

PHYSICAL EXAM REVIEW - MENTOR USE ONLY:

Additional exams: ☐ **H/N** ☐ **Cardio.** ☐ **Resp.** ☐ **Abdo.**

☐ **Upper limb** ☐ **Lower limb**

Indications for x-rays from patient history:

_____

_____

<u>At the completion of the physical exam</u>:

Are x-rays required based on history and physical exam findings?

☐ **Yes** / ☐ **No**

Views: ☐ **F/Spine** ☐ **Cervical** ☐ **Thoracic** ☐ **Lumbar**

Other: _____

Mentor Signature: _____

DDX 1:
Hallmarks:
Exams:
DDX 2:
Hallmarks:
Exams:
DDX 3:
Hallmarks:
Exams:
DDX 4:
Hallmarks:
Exams:
DDX 5:
Hallmarks:
Exams:
DDX 6:
Hallmarks:
Exams: