NECKSBACKSSPORTS
Gentle Effective Care

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Welcome to Necks Backs Sports

Please take the time to answer these questions as accurately as possible, as this will assist us in providing the best care for you. If you have any questions or concerns, do not hesitate to ask for assistance.

Please also use CAPITAL LETTERS and print clearly, thank you.

Part A: Patient Details*

1. Title (Dr/Mr/Mast./Mrs/Ms/Miss/Other): ☐☐☐☐☐☐ 2. Gender: ☐ Male ☐ Female ☐ Other

3. Surname:

4. First Name:

5. Preferred Name:

6. Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ 7. Occupation:

8. Address:

9. Suburb: 10. Postcode:

11. Phone (Home): 12. Phone (Work):

13. Mobile:

14. Email:

We provide a reminder service 2 days before any future appointment.

15. Please nominate which service you would prefer (*tick one*): ☐ SMS ☐ Email

16. I give Necks Backs Sports permission to send me emails for purposes such as receipting, reminders and healthcare news/research updates: ☐ Yes ☐ No ***Signature:*** ____________________________

Emergency Contact Details

17. Contact Name: ____________________________ 18. Relationship: ____________________________

19. Contact Number:

20. How did you find out about this clinic? (*Please tick an option below*)

☐ Internet Search: __________ ☐ Website ☐ Facebook ☐ Instagram

☐ Signage/Travelled Past ☐ Poster/Advert ☐ Brochure/Flyer ☐ Seminar

☐ From my G.P./Doctor: ____________________________ ☐ A Friend: ____________________________

☐ From my Trainer/Coach: ____________________________ ☐ Other: ____________________________

21. Do you have private health insurance? ☐ No ☐ Yes - Fund Name: ____________________________

22. Are you claiming through Workers Compensation or CTP? ☐ No (*Go to 23*) ☐ Yes (*complete below*)

Claim No: ____________________ Date of Injury: ____/____/______ Insurer: ________________ Case Manager: ______________________

23. *Conditions of Consultation*

I hereby acknowledge and understand that should my claim be rejected in any way that I will be responsible for payment of accounts for any and all chiropractic services received. I understand that should I cancel or not attend a future scheduled appointment without providing at least 24 hours' notice that a fee of $55 will be charged. Not attending an appointment is an inconvenience to both the clinic and our other patients (as it takes the spot of another patient who may have been able to attend in your place), and generally also disrupts your treatment progress. ☐ ***Signature:*** ____________________________________

**Please note that your details are kept by Necks Backs Sports for the purposes of healthcare delivery and communications and are not disclosed to any third party without written consent.*

PART B. Medical History

1. Name of your G.P./Doctor: ______________________________

2. Contact Number: ______________________________

3. Address or Clinic Name: ______________________________

4. I give permission for my health practitioner to be contacted: ☐ ***Signature:*** ______________

5. Have you had any accidents or fractures? (*tick one*) ☐ No (*Go to 6*) ☐ Yes (*complete below*)

   Please list all accidents and/or fractures (including dates): ______________________________

6. Have you had any hospital admissions or surgeries? (*tick one*) ☐ No (*Go to 7*) ☐ Yes (*complete below*)

   Please list (including dates and details): ______________________________

7. Have you had any x-rays or other imaging taken before? ☐ No (*Go to 8*) ☐ Yes (*complete below*)

   Please list (including dates and details): ______________________________

   Where did you have these images taken? ______________________________

8. Have you had your blood pressure measured before? ☐ No (*Go to 9*) ☐ Yes (*complete below*)

   Is your blood pressure usually: (*tick one*) ☐ Low ☐ Normal ☐ High

   Last blood pressure reading: ________/________ Date taken: _____/_____/________

9. Are you taking any medication or supplements? ☐ No (*Go to 10*) ☐ Yes (*complete below*)

   Please list all medication and/or supplements: ______________________________

10. Do you have any allergies? ☐ No (*Go to 11*) ☐ Yes (*complete below*)

    Please list all allergies: ______________________________

11. Do you currently have or have had any of the following symptoms/conditions? (*Please tick all that apply*)

☐ Heart Disease ☐ Pace Maker ☐ Rheumatic Fever ☐ Stroke

Name of Heart Specialist: ______________________ Date of last check-up: _____/_____/_______

Address or Clinic Name: ______________________ Contact Number: ______________

I give permission for my health practitioner to be contacted: ☐ ***Signature:*** ______________

☐ Aids/HIV	☐ Anaemia	☐ Arthritis: ___________	☐ Asthma
☐ Cancer: ________________	☐ Chronic Fatigue	☐ Depression	☐ Diabetes
☐ Epilepsy	☐ Glandular Fever	☐ Glaucoma	☐ Hepatitis
☐ Herniated Disc	☐ High Cholesterol	☐ Meningitis	☐ Migraines
☐ Multiple Sclerosis	☐ Osteoporosis	☐ Pinched Nerve	☐ Pneumonia
☐ Rheumatoid Arthritis	☐ Shingles	☐ Thyroid Problems	☐ Tuberculosis

☐ Other: (*Please list*) ______________________________

PART B. Medical History (cont.)

12. Do you have children? (*tick one*) ☐ No (*Skip 13*) ☐ Yes (*Go to 13*)

13. How many children do you have [and age(s)]? ______________________

Female Patients

14. Are you Pregnant? (*tick one*) ☐ No (*Go to 15*) ☐ Yes (*complete below*)

What is your due date? _____/_____/__________ Name of Obstetrician: ______________________

Address or Clinic Name: ______________________ Contact Number: ______________________

I give permission for my health practitioner to be contacted: ☐ ***Signature:*** ______________________

15. Are you Nursing? (*tick one*) ☐ No ☐ Yes

PART C. Daily Habits

1. Occupation: ______________________ 2. Company: ______________________

3. Level of exercise/activities performed on a daily basis: ☐ None (*Go to 5*) ☐ Light ☐ Moderate ☐ Heavy

4. What type of exercise/activities do you do? ______________________

5. Are you a member of a Gym? ☐ No ☐ Yes – Gym: ______________________

6. Do you have a Personal Trainer? ☐ No ☐ Yes – Name: ______________________

7. Are you a member of a Sports Team? ☐ No ☐ Yes – Team: ______________________

8. Do you smoke? ☐ No ☐ Yes – Average amount: ______________________

9. Do you drink alcohol? ☐ No ☐ Yes – Average standard alcoholic drinks: ______________________

10. Do you drink caffeinated drinks? ☐ No ☐ Yes – Average amount: ______________________

PART D. Symptoms

1. Reason(s) for Visit: ______________________

____

2. What are TWO main things that you would like to achieve by the end of today's consultation? (*detail below*)

a) ______________________

b) ______________________

3. Why is it important to you that you get rid of your problem/injury as soon as possible? (*describe below*)

____

____

4. In which part(s) of the body is the problem/injury located? ______________________

5. When did you first notice the symptom(s)? ______________________

6. Do you know how the symptom(s) started? ______________________

7. Frequency of your symptom(s): ☐ Constant ☐ Intermittent ☐ Activity Dependant: ______________________

8. Severity of your symptom(s): ☐ Increasing ☐ Decreasing ☐ Not Changing

9. Have you seen another health professional (e.g., G.P, Chiropractor, Physiotherapist, Massage Therapist, etc.) about this before? ☐ No (*Go to 13*) ☐ Yes – Name/Location: ______________________

10. Please list the type of treatment received: ______________________

11. Is there anything that you were *not* happy with? ☐ No ☐ Yes – Details: ______________________

12. What aspects were you *most* happy with? ______________________

PART D. Symptoms (cont.)

Please answer the following about how the pain makes you feel and your response to it.

13. How long have you had your current pain problem? (*tick one*)

☐ 0-1 week [1] ☐ 1-2 weeks [2] ☐ 3-4 weeks [3] ☐ 4-5 weeks [4] ☐ 6-8 weeks [5]
☐ 9-11 weeks [6] ☐ 3-6 months [7] ☐ 6-9 months [8] ☐ 9-12 months [9] ☐ Over 1 year [10] — *x* ☐

14. How would you rate the pain that you have had during the past week? (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
No pain → Pain as bad as it could be — *x* ☐

15. How tense or anxious have you felt in the past week? (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
Absolutely calm and relaxed → As tense and anxious as I've ever felt — *x* ☐

16. How much have you been bothered by feeling depressed in the past week? (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
Not at all → Extremely — *x* ☐

17. An increase in pain is an indication that I should stop what I'm doing until the pain decreases (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
Completely disagree → Completely agree — *x* ☐

18. I should *not* do my normal work (at work or home duties) with my present pain (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
Completely disagree → Completely agree — *x* ☐

19. In your view, how large is the risk that your current pain may become persistent? (*circle one*)

0 1 2 3 4 5 6 7 8 9 10
No risk → Very large risk — *x* ☐

20. In your estimation, what are the chances you will be working your normal home or work duties in 3 months?

0 1 2 3 4 5 6 7 8 9 10
No chance → Very large chance — **10-*x*** ☐

Please circle the number that best describes your current ability to participate in each of the following activities.

21. I can sleep at night.

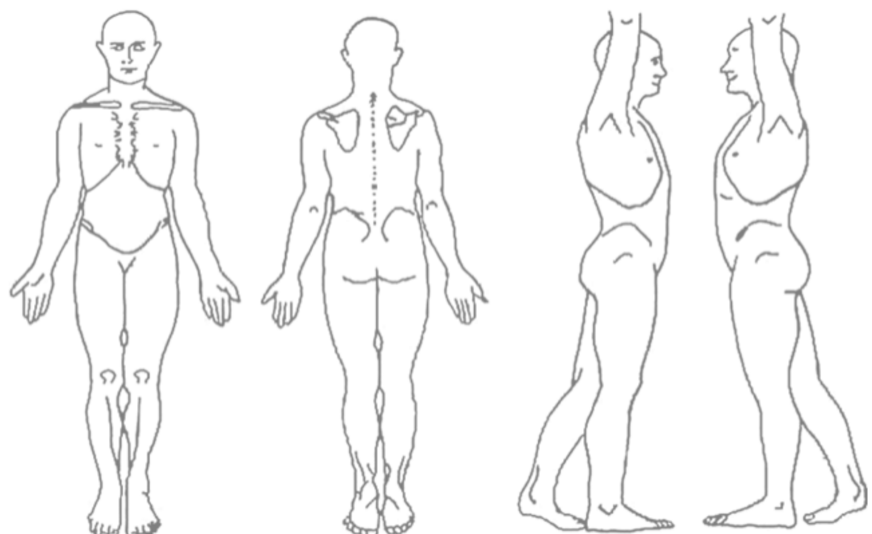
0 1 2 3 4 5 6 7 8 9 10
Not at all → Without any difficulty — **10-*x*** ☐

22. I can do light work (or home duties) for an hour such as lifting, carrying or moving objects <5kg.

0 1 2 3 4 5 6 7 8 9 10
Not at all → Can do it without pain being a problem — **10-*x*** ☐

Linton, Nicholas, & MacDonald, 2011. Örebro Musculoskeletal Pain Screening Questionnaire (Short-form) **Score:** _____

23. Using the symbols below, please mark on these pictures the location of ALL the pain or other symptoms that you feel (even if it is unrelated to your reason for visiting the clinic today).



*** Use Stars for SHARP PAIN
✓✓ Use Ticks for DULL PAIN
+++ Use Crosses for STIFFNESS
○○ Use Circles for OTHER: ____________