Intern: _____

Chiropractic Centre | New Zealand College of Chiropractic

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:

_____

_____

_____

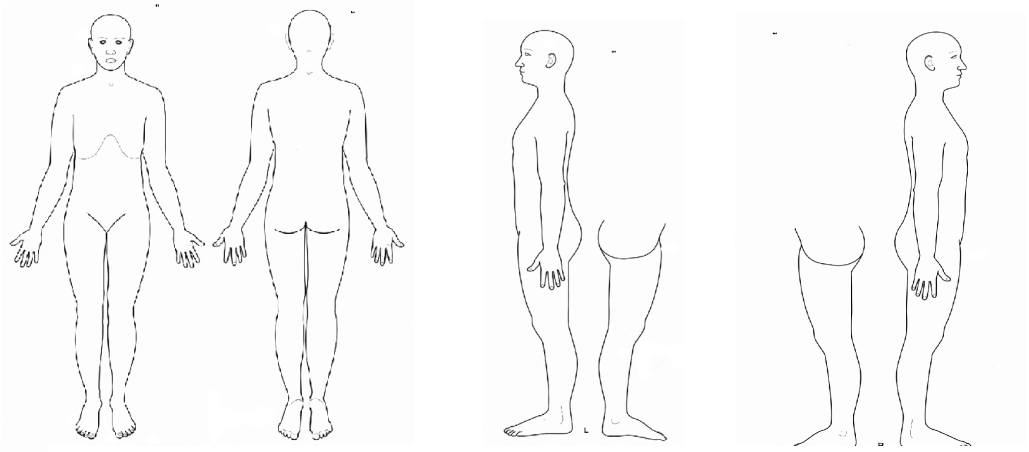
Please state whether there are certain activities you would like assistance improving:

_____

_____

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: _____

Chiropractic Centre | New Zealand College of Chiropractic

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: COVID, pneumonia, etc
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

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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

Sex at birth: _____

(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, 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?

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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: