disc bulge CLINIC

new patient form

confidential health history

Please answer all questions as best you can and sign the consent at the end of this form. Some of the following questions may seem irrelevant to your case. However, they assist us in delivering the safest and best possible care, and many are required by law. All information you give is private and confidential.

personal details

Full Name _____ I prefer to be called _____

Male ☐ Female ☐ Date of Birth _____ Age _____

Single ☐ Married ☐ No. of children ☐

Occupation _____

Address _____

Home phone _____ Work phone _____ Mobile _____

Email _____ NHI Number _____

Your medical doctor _____ Chiro/Physio/Osteo _____

Consultant _____ Hospital _____

How did you hear about our service (e.g. referral from GP, friend, phonebook) _____

Emergency contact, name _____ phone _____

current health condition

Reason for this appointment (e.g. wellness care, prevention, low back pain, headaches, posture)

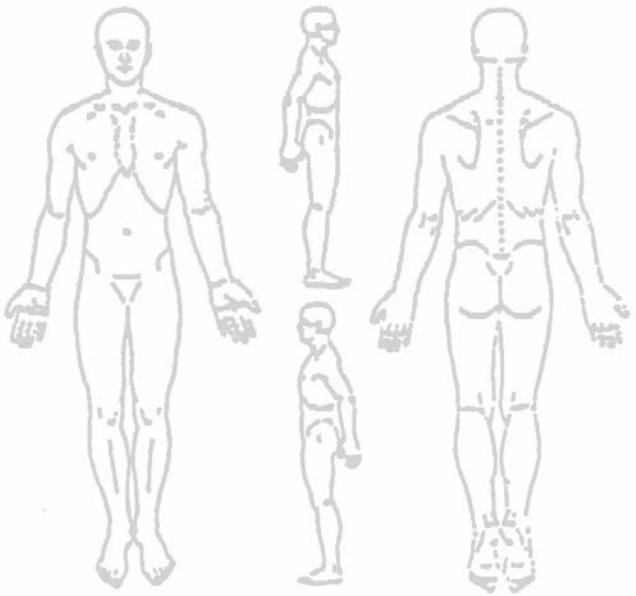
_____

When did your problem begin (date or number of days, months, years) _____

How did this probem begin (e.g. accident, lifting, work related, gradual onset) _____

Please mark any areas of pain or disconfort on the diagrams and label with the letter that best describes it.

S = Sharp / Stabbing
D = Dull / Achy
P = Pins & Needles
N = Numbness
B = Burning
O = Other



Practitioners seen for this problem (e.g. GP, Physiotherapist)

_____

Does anything make it better (e.g. position, rest, ice)

_____

Does anything make it worse (e.g. standing, bending, coughing)

_____

Current mediactions

Pain killers ☐ Muscle relaxants ☐

Corticosteroids ☐ Blood Pressure pills ☐

Birth control ☐ Vitamins ☐

Others (please list)

_____

overall health status & health history

Have you experienced any of the following in the last 12 months?

Neuro-musculo-skeletal

- ☐ Low-Back Pain
- ☐ Neck Pain
- ☐ Pain between Shoulders
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Walking Problems
- ☐ Stiffness
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness
- ☐ Tingling, Burning, or
- ☐ Pins & Needles
- ☐ Weakness
- ☐ Paralysis
- ☐ Dizziness / Vertigo
- ☐ Fainting
- ☐ Anxiety
- ☐ Confusion
- ☐ Depression
- ☐ Convulsions

Cardio-vascular

- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Stroke
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Lung Problems
- ☐ Ankle Swelling
- ☐ Varicose Veins

Genito-urinary

- ☐ Bladder Problems (eg. changes to frequency, volume, control)
- ☐ Painful Urination
- ☐ Discoloured Urine
- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Infection / Disease
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Breast Pain / Lumps
- ☐ Prostate Problems

Gastro-intestinal

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Significant Weight Loss
- ☐ Significant Weight Gain
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Heartburn / Reflux
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Bowel Problems (e.g. bleeding, constipation, gas, diarrhoea, cramps)

Females only

Are You Pregnant?

- ☐ Yes
- ☐ No
- ☐ Unsure

Ears/eyes/nose/throat

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Ear Ache
- ☐ Sore Throat
- ☐ Hearing Difficulty

General

- ☐ Stress
- ☐ Loss of sleep
- ☐ Fever
- ☐ Chronic / Recurrent Infections

Other

When were you last x-rayed?

Have you ever had any other imaging (e.g. MRI, CT scan)?

☐ Yes ☐ No

Please tick if you have, or have ever had, any of the following conditions:

- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Osteoporosis

Other (e.g. HIV or AIDS, Hepatitis, Psoriasis, Polio, Epilepsy etc)

Have you been treated for any other health condition in the last year? ☐ Yes ☐ No

If yes, please give details

Surgery/operations (e.g. Appendix, C-section, Hip-Replacement, Discectomy)

Significant accidents, injuries, or falls (include major childhood injuries, vehicle accidents)

Hospitalisation (other than above)

Family history of major illnesses (e.g. breast cancer, diabetes)

lifestyle assessment

On a scale of 1 to 10 how do you presently feel? (mark on line)

1 worst — 10 best

When did you last feel 100%? _____

What activities of daily living are most affected by your current condition (e.g. dressing, sleeping, sport, gardening)

_____

Do you mainly sleep on your ☐ Side ☐ Back ☐ Stomach

Do you smoke? ☐ No ☐ Yes ☐ Past How many cigarettes per day? _____

Currently, what are the 3 healthiest activities in your life? (e.g. exercise, meditation, balanced nutrition, good hydration)

1 _____

2 _____

3 _____

Currently, what are the 3 least healthy activities in your life? (e.g. smoking, poor nutrition or hydration, stress)

1 _____

2 _____

3 _____

Patient name _____

Patient Signature _____ Date _____

(consent for examination & care)

Thank you for filling out this important information.
Enjoy your visit and the many benefits of Decompression Therapy!

I have read and understood the Disc Bulge therapy consent form and accept the risks of potentail side-effects as described in the consent form.

Patient Signature (consent for examination & care) _____ Date _____

examination analysis Practitioner to complete

Vitals

BP _____

Pulse _____

Height _____

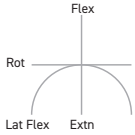
Weight _____

BMI _____

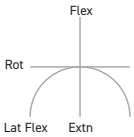
Range of motion

SI Joint

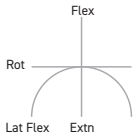
Lumbar



Thoracic



Cervical



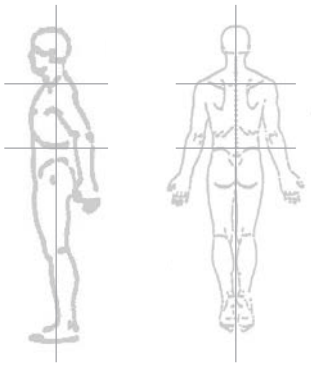
TMJ

mm _____

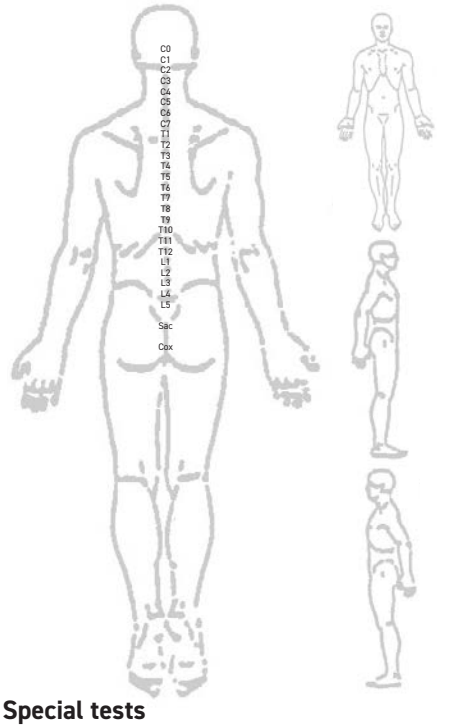
Posture

standing _____

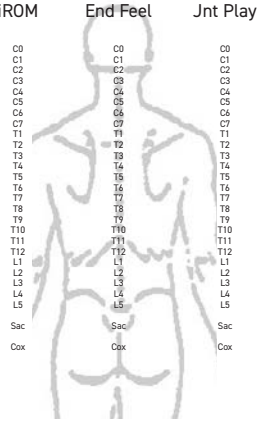
sitting _____



Palpation



iROM End Feel Jnt Play



Special tests

Cranial nerves I II II,IV,VI V VII VIII X XI XII

Cerebellar/Posterior column function

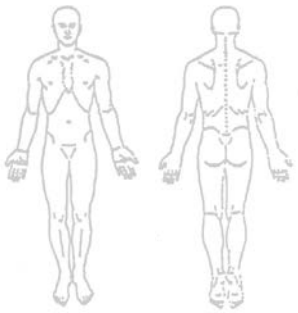
Rhomburgs Dysdiadochokinesis Proprioception Vibration sense Fine touch

Reflexes

	Left	Right
Biceps (C5)		
Brachioradialis (C6)		
Triceps (C7)		
Patellar (L4)		
Achilles (S1)		

Abdomnial / Babinski / Clonus

Sensory



Leg length inequality

L/R _____ mm

+/– Derefield

Cervical Stndrome C1 C2 C3-7

Muscle Strength /5

	Left	Right
Hip Flex		
Knee Ext		
Knee Flex		
Dorsiflex		
Plantar Flex		
Inversion		
Eversion		
Hallucis Ext		
Hallucis Flex		
Elbow Flex		
Elbow Ext		
Arm Abd		
Arm Add		
Wrist Ext		
Wrist Flex		
Grip strength		
Finger Flex		
Finger Ext		
Finger Abd		
Opposition		

Orthopaedic

standing	L	R	
Adams			
F2T distance.			cm
Trendelenburg			
Toe Walk			
Heel Walk			
Underburgs			

seated			
Maignes			
Compression			
Foraminal Comp.			
Distraction			
Shoulder Dep.			
Kemps			
Appleys Scratch			
TOS - Allens			
Addsons			
Edens			
Wrights			

supine	L	R	
SLR			
WLR			
Braggard			
Patrick Fabere			
Internal Hip Rot			
Occ Challenge			
Valsalva			
Soto Hall			

prone			
Nachlas			
Yeomans			
Ellys			
Hibbs			
Sac comp			
Sac ext			

malingering

Mankopff Plantar Flex Burns bench McBride Hoover

Analysis/Clinical impression

Other notes

Plan of management

☐ x ☐ wks ☐ x ☐ wks

reassess

☐ x ☐ wks ☐ x ☐ wks

Stretches

- ☐ C/S ROM
- ☐ C/S Stretches
- ☐ S/O Traction
- ☐ Shldr Rot
- ☐ Pectoralis
- ☐ Cat
- ☐ Psoas/Hip
- ☐ Flexors
- ☐ Knee to Shldr
- ☐ Lumbar X roll
- ☐ Hamstrings
- ☐ Gastroc
- ☐ Other

Strengthening

- ☐ C/S isometrics
- ☐ Traps
- ☐ Abs–upper/lower
- ☐ Superman
- ☐ Other

Referral

- ☐ X-ray
- ☐ Gait scan
- ☐ GP
- ☐ Other

DC Signature

_____

Date

_____