



# 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 \_\_\_\_\_

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

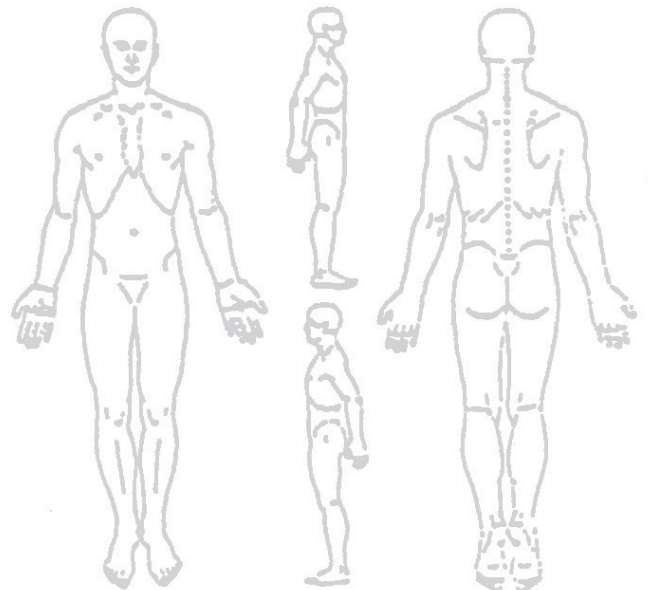
Reason for this appointment (e.g. wellness care, prevention, low back pain, headaches, posture) \_\_\_\_\_

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

How did this problem begin (e.g. accident, lifting, work related, gradual onset) \_\_\_\_\_

Please mark any areas of pain or discomfort 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 medications

Pain killers <input type="checkbox"/>	Muscle relaxants <input type="checkbox"/>
Corticosteroids <input type="checkbox"/>	Blood Pressure pills <input type="checkbox"/>
Birth control <input type="checkbox"/>	Vitamins <input type="checkbox"/>
Others (please list) _____	

# overall health status & health history

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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?

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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) \_\_\_\_\_

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# lifestyle assessment

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

When did you last feel 100%? \_\_\_\_\_

1  
worst

10  
best

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

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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 Signature** (consent for examination & care) \_\_\_\_\_ Date \_\_\_\_\_

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


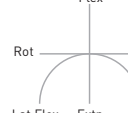
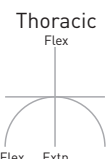
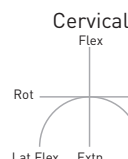
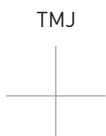
I have read and understood the Disc Bulge therapy consent form and accept the risks of potential side-effects as described in the consent form.

**Patient Signature** (consent for examination & care) \_\_\_\_\_ Date \_\_\_\_\_

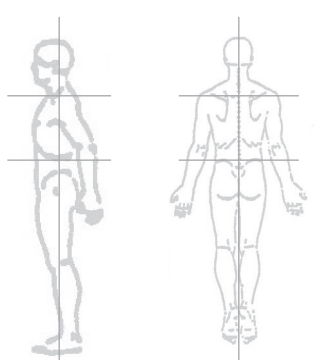
**Vitals**

BP \_\_\_\_\_  
 Pulse \_\_\_\_\_  
 Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 BMI \_\_\_\_\_

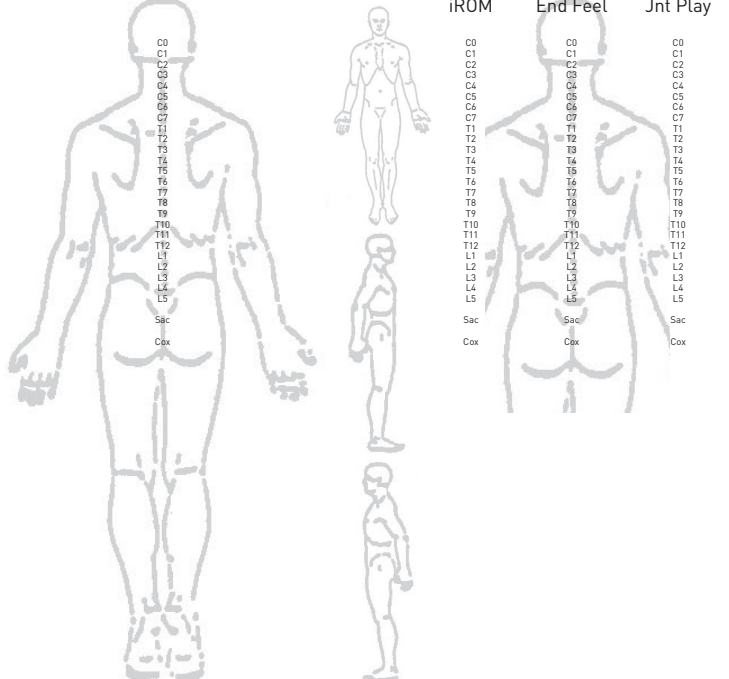
**Range of motion**

**SI Joint**  
  
**Lumbar Flex**  
  
**Thoracic Flex**  
  
**Cervical Flex**  
  
**TMJ**  
  
 mm \_\_\_\_\_

**Posture**

standing \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 sitting \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  


**Palpation**



**Special tests**

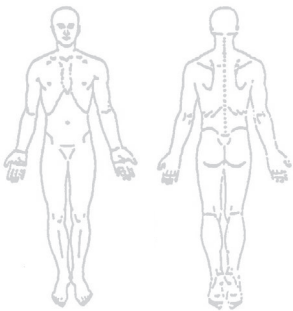
Cranial nerves I II II,IV,VI V VII VIII X XI XII  
 Cerebellar/Posterior column function  
 Rhomburgs Dysdiadochokinesis Proprioception Vibration sense Fine touch

**Reflexes**

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

Abdominal / Babinski / Clonus

**Sensory**



**Leg length inequality**

L/R \_\_\_\_\_ mm  
 +/- Derefield  
 Cervical Sndrome 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.		
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**