Examination / Analysis
(Chiropractor to complete)

Vitals : BP ______/______mmHg Pulse ______bpm

Height _________m Weight _______kg BMI _______

Postural Analysis

Notes: standing

sitting

Range of Motion

SI Joint | Lumbar | Thoracic | Cervical | TMJ

Flex. Rot Lat. Flex Extn. ____ mm

Reflexes:

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

Abdomnial / Babinski / Clonus

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		

Sensory:

Orthopaedic:

/ standing

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

/ seated

	L	R
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

	L	R
Nachlas		
Yeomans		
Ellys		
Hibbs		
Sac comp		
Sac ext		

/ malingering Mankopff Plantar Flex Burns bench McBride Hoover

Leg Length Inequality L / R ______ mm + / - Derefield

Cervical Syndrome C1 C2 C3-7

Palpation findings:

iROM End Feel Jnt Play

C0 C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 Sac Cox

Special Tests:

Cranial Nerves:

I II III, IV, VI V VII VIII VIIII X XI XII

Cerebellar / Posterior Column function:

Rhomburgs Dysdiadochokinesis Proprioception Vibration Sense Fine Touch

Regional exam / Other:

Other Notes:

Analysis / Clinical Impression:

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

Other recommendations:

Referral:
X-ray
Gait Scan
GP
Other

DC Signature ________________________ Date ________________

confidential health history

koru chiropractic
WELLNESS CENTRE

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: _______

Marital Status: Single☐ Married☐ Number of Children (if any): ______

Occupation: _____________________________________

Address: ____

Telephone: Home- __________________ Work- _________________ Mobile- _________________

Email: ____

Your Medical Doctor: ______________________________________ Consent to contact if required☐

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

____

Have you ever had Chiropractic Care before: Yes☐ No☐ ____________________________

Current Health Condition

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

____

When did your problem begin (date or number of days, months, or 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 ☐ Muscle Relaxants ☐ Corticosteroids ☐ Blood Pressure Pills ☐

Birth Control ☐ Vitamins ☐ Others ☐ List names and dosage if possible:

____

Have you previously been on any long-term medications? Yes ☐ No ☐ ______________

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

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)

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

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 (eg. MRI, CT scan)? No ☐ Yes ☐ ______________

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 explain: ______________

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

____

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

____
____
____

Hospitalisation (other than above): ______________

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

____

Lifestyle Assessment

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

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: Present ☐ / 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. ______________

Chiropractic acknowledges that the body has an innate ability to heal. Chiropractors strive to assist the natural healing response by correcting ***subluxations****. Abnormal joint motion and alignment (subluxations) cause nerve interference by irritating or placing pressure on the spinal cord and nerves and altering neuro-biologic integration. The nervous system is vitally important to our wellbeing as it controls and co-ordinates all functions of the body. If the flow of nerve information around the body is disrupted, the healing response is compromised, and many health problems can arise.*

Patient Signature (consent for examination & care): ______________ Date: ____________

Thank you for filling out this important information.

Enjoy your visit and the many benefits of Chiropractic Care!