Initial Consultation Questionnaire

lifewise
network care adelaide

The following information is confidential and will assist us in determining your current and past health status.

Name ..... Date of birth ...../ ...../ .....

Address .....

Phone ..... Email .....

Occupation .....

Relationship status ..... Children (number) ..... Ages .....

Emergency contact name & phone .....

How did you hear about this office? .....

What would you like to receive from care in this office?
(please tick as many as applicable)

- ○ Symptom relief
- ○ Prevent future problems
- ○ Improved health & wellbeing
- ○ Less tension / greater flexibility
- ○ Improved capacity to cope with stress
- ○ Better posture
- ○ Greater energy levels
- ○ Improvement in my enjoyment of life and ability to make constructive choices

What is your main area of concern?
(If you do not have a concern and are here for wellness care only please turn to "General Health")

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When did this problem start? .....

Do you know what caused your problem? .....

What makes it better? .....

What makes it worse? .....

How frequent is it? *(please circle)*

Constant (100%) Frequent (>50%) Occasionally (25-49%) Intermittent (<25%)

Are your symptoms *(please circle)*

Increasing Decreasing Not changing

Have you had any previous treatment for this problem? Did it work?

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What affect does this have on your life (mood, daily activities, sleep, productivity or focus at work, fatigue, social and leisure activities, family interactions, etc).

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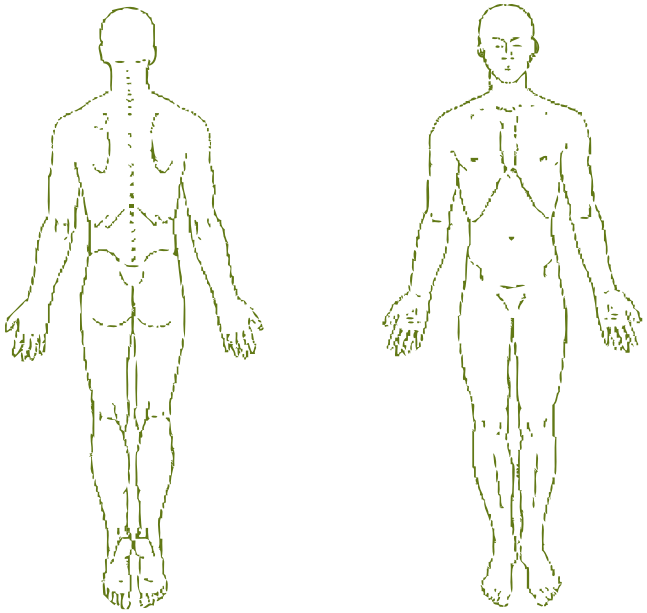
Please use the diagrams to indicate the main area of concern as well as any other areas of pain, stiffness, discomfort or injury in your body:



General Health

Do you have or experience any of the following symptoms or conditions? *(please tick as many as applicable).*

- ○ Fever
- ○ Nausea
- ○ Chest pain
- ○ Dizziness
- ○ Neck stiffness
- ○ Jaw tension or grinding
- ○ Headaches or migraines
- ○ Numbness/tingling
- ○ Excess fatigue
- ○ Visual changes
- ○ Trouble talking
- ○ Night pain
- ○ Changes in balance or coordination
- ○ Changes in normal muscle strength
- ○ Changes in hand/feet temperature
- ○ Weight changes (recent gain/loss)
- ○ Digestive troubles or bloating
- ○ Diarrhea/constipation
- ○ Breathing difficulties
- ○ Ringing in ears
- ○ Cholesterol problems
- ○ High or low blood pressure
- ○ Arthritis
- ○ Osteoporosis
- ○ Anxiety/depression
- ○ Hormonal problems
- ○ Poor circulation
- ○ Bladder or kidney troubles
- ○ Reproductive system troubles/ painful periods
- ○ Allergies or sinus troubles
- ○ Skin problems
- ○ Difficulty sleeping

List any other major conditions or surgeries (past or present).

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Do you have any family history of Cancer, Stroke or Heart Disease?

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The care you will receive at this office will help you release tensions from your spine, nervous system and body. Tensions build up due to physical, emotional and chemical stresses you experience. The following questions will help me gain an understanding of the stresses you have experienced up until now.

Physical Stress

Please list all of the major physical traumas you have had (falls, car accidents, sporting injuries, broken bones, etc) along with the date they occurred. Please include any major falls, etc that may not have resulted in an injury at the time.

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Please list any prolonged postures or positions you hold your body in for extended periods, past or present (eg. mobile phone or tablet use, sitting at a computer, breastfeeding etc).

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Chemical Stress

Please list any current medications, reasons for taking them and when prescribed *(if applicable).*

Past significant medications (strong pain killers, anaesthetics, steroids etc).

Have you been exposed to any major chemical toxins in your life?

Do you now or have you ever smoked cigarettes?

Briefly describe your diet (meat and vegetables, vegetarian, artificial sweetners, refined foods, health supplements/ natural remedies).

How many cups of coffee/tea do you drink per day? *(please circle)*	0	1-2	2-3	4-7	9+
How many glasses of water do you drink per day? *(please circle)*	0	1-2	2-3	4-7	9+
How many glasses of alcohol do you drink per week on average? *(please circle)*	0	1-2	2-3	4-7	9+

Psychological Stress

Please list **significant** mental/emotional stresses you have experienced from birth until now, along with your age at the time (eg. family break ups, deaths, school or work stresses, change in lifestyle, abuse, traumatic events, etc).

Current mental/emotional stresses (work, relationships, health concerns, financial, social, info overload, tech addiction etc).

Further Questions

Please think about how you are feeling right now, your general sense of health and wellbeing. Make a straight vertical mark on the line below to show how you would rate this.

What types of treatments or activities, past and present, have you used for improving your health, for stress relief or for personal development? (eg doctor, physio, naturopath, massage, meditation, exercise, etc)?

Is there anything else about your health or life circumstances which you think may be relevant?

Important Information

At Lifewise we use a non-manipulative form of Chiropractic called Network Care which is noted for being extremely gentle and for the profound results produced. This care will help you release tension and stored energy from your spine and nervous system.

Research has shown that Network Care dramatically improves people's enjoyment and quality of life, with benefits including: greater flexibility and energy levels, improved physical and emotional symptoms, better posture, increased general wellbeing, greater mental clarity and an increased ability to cope with stress.

In what are called Network Adjustments we use very precise and gentle touches, mainly at either end of your spine on your neck and sacrum and coccyx (tailbone). So you can anticipate what will happen, please understand the contact on the coccyx is at the very lower tip of your spine, situated between your upper buttocks. These contacts address the underlying tension patterns in your body. If at any stage you are uncomfortable with what we are doing please ask us to stop immediately so that we can discuss.

During adjustments you may notice changes in your breath and/or areas of your body spontaneously moving (rocking, stretching, twitching etc.). These movements and the flow of breath unwind tension built up around your spine. For the best results in your care, please try to allow/encourage your body in this process as much as possible. If you consciously feel the need to stretch or move please do so.

Because there is no manipulation or "cracking" involved in the technique and very little force the risks involved in the adjustments are very minimal. As you progress we may stretch and position you in different ways, but will always bear in mind any physical limitations.

During or after adjustments many people occasionally notice symptoms or aches and pains intensifying or shifting to areas that haven't been sore before. This happens as your body connects and releases old tension. It may happen straight away or after several visits. It is usually short lived. Let us know if you do notice anything, and if it concerns you please contact me straight away. We're always happy to answer any questions about any aspects of care.

With this technique the benefits are not necessarily immediate. It can take a few visits over a short time for you to notice change occurring. This varies from person to person. We will be carefully watching for change in your body. If we see little change in the first 3 to 4 visits we will review your progress immediately.

Please note: We do not accept any third party cases such as Workcover, Motor Vehicle Accident or Department of Veterans Affairs.

I understand the above and consent to care.

Signed .....

Name (printed).....

Date ...../...../.....