

WELCOME TO CHIROPRACTIC HEALTH CENTRE YOUR CONFIDENTIAL INFORMATION

16-59

Name:		Date:	
Address:		Suburb:	Postcode:
Home Phone:		Work Phone:	Mobile:
DOB:	Age:	Email:.....	
Marital Status: M Defacto W D S		<input type="checkbox"/> Tick if you do not wish to receive information by email	
Occupation:		Employer:	
Partners Name:		Partner's Occupation:	
Children's Names and Ages:			
Do you have Private Health Cover? Yes No Which One?			
Your Medicare No:		Exp. Date:	Reference No:
Your Previous Chiropractor's Name:		Date of Last Visit:	
Who Recommended You To Our Centre?			

**Most people, including children, have experienced many things that could cause spinal misalignments or "Vertebral Subluxations".
Vertebral Subluxation affects your nervous system which affects your whole health.**

Please describe your **primary health concerns** or reasons for consulting our office:

1. _____ for how long? _____
2. _____ for how long? _____
3. _____ for how long? _____

What do you think caused this problem(s)? _____

Other Doctors you have seen for this condition(s)? _____

Please tick/circle any of the following symptoms you have experienced:

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck pain / stiffness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Leg pain / Cramps |
| <input type="checkbox"/> Numbness/Tingling in arms/hands | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Numbness / tingling in legs or feet |
| <input type="checkbox"/> Dizziness / Ringing in ears | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Reflux | <input type="checkbox"/> Constipation / Diarrhoea |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Difficult / frequent urination |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> High / Low Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Recurrent Colds | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Menstrual Problems | |

Does this cause you to be: (please circle)

Moody Irritable Have interrupted sleep Be restricted in daily activities

How does this affect your life and work? (please circle)

Results in poor attitude? Are you exhausted at the end of the day?

Hinders participation in sport/exercise? Restricted in household duties?

Do you lose patience with spouse and/or children? In decision making?

Results in decreased productivity at work?

List ALL **surgeries**. What year?

List ALL **medications** you currently take (including vitamins,herbs):.....

Have you ever been diagnosed with Cancer or other serious disease?

Accident and Trauma History

Spinal Misalignments or “Vertebral Subluxation” are caused by things in life like car accidents, slips or falls, work and sporting injuries, poor posture, childhood falls, etc. Please list with as much detail as possible all impacts, large and small throughout your entire life. Motor Vehicle Accidents (Did you know that the maximum speed to cause Subluxation is only 13km/hr)

1. When?..... What Speed?..... Impact? *Front side back stationery*
Injuries Treatment?
2. When?..... What Speed?..... Impact? *Front side back stationery*
Injuries Treatment?

Work / Home

Hours worked per week:..... At work, do you mainly? Sit Stand Lift Bend twist

Describe your most recent slip strain, twist or fall at work or home: When?

What Happened?..... Treatment?.....

Sports & Recreation

What sports or recreation do you enjoy?

Any accidents or injuries?

When? (year) Treatment?.....

Any broken bones, fractures, reconstructions?

Childhood Injuries

Do you recall any significant falls/accidents/injuries as a child/teenager? When? (year)

Is there any chance you are PREGNANT Yes No Are you BREAST FEEDING? Yes No

Do you use any of the following? Orthotics Heel Lift Arch Supports

Informed Consent

Changes to the law now require all practitioners who adjust the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 5.85million)¹. Whilst this has never occurred in this practice, we are still required to warn you.

In other extremely rare circumstances there may be strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (less than 1 in 62,000)². Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives³.

We use very gentle adjustments to minimise these risks. Should our chiropractor accept your case for chiropractic care and you have any questions related to the treatment you may receive, please contact this office immediately.

1. Neck Manipulations. Haldeman, et al. Spine vol 24-8, 1999 2. Dvorak Study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed
3. A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.

Based on the information provided I consent to receiving chiropractic care by a registered Chiropractor in this centre, and I acknowledge that I have read and understood the information contained in this document. I understand that I can withdraw my consent at any time.

The above information is true and accurate to the best of my knowledge.

Patient or Carer Signature : Date:.....



Office Use Only
L R.....
<input type="checkbox"/> FHP <input type="checkbox"/> L <input type="checkbox"/> R Pronation <input type="checkbox"/> L <input type="checkbox"/> R VAT
Notes:
.....
.....
R1 Call: