Client details

Date ____________________ Case no. ________________

Title _________ First name _____________________ Last name ______________________

Preferred name _______________________________________

Date of birth _____/_____/________ Age _______ Gender M / F

Occupation _______________________________________

Employer _______________________________________

Current address _______________________________________

____

PO Box _______________________________________

____

Phone Home ________________ Mobile ________________ Work __________________

Email ____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ De facto

Emergency Contact Name ______________________________

Relationship to you __________________________ Telephone _______________________

Number of children living at home _______________________

Private Health Fund _____________________________________

Referred by ____

Preferred contact method ☐ SMS ☐ Phone/mobile

informed consent to chiropractic care

Changes in the law now require all practitioners who adjust the spine to warn clients of material risks. Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures including assessment and treatment, which you should be informed about.

In extremely rare circumstances, chiropractic care of the neck may damage blood vessels and give rise to stroke or stroke-like symptoms (current statistics less than 1 in 2 million to 1 in 5.85 million-Halderman, et al. Spine vol 24-8 1999). Other very slight risks including strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000-Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed.). For some clients with bone weakening diseases, a fracture of a bone although rare is possible.

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 alternatives (A Risk Assessment of Cervical Manipulation, JMPT, 1994. Manga Report, Ontario Ministry of Health, 1993).

I have been given the opportunity to discuss the proposed care and the above information with the Chiropractor and ask questions and give my consent to chiropractic care. I hereby acknowledge my consent to the performance of the proposed chiropractic care by any chiropractor working in this clinic. I understand I can withdraw consent at any time.

I acknowledge that I am aware of and understand the potential risks which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fracture, disc injuries including disc encroachments/ruptures causing nerve irritation and referred symptoms, strokes or like episodes and exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like. I appreciate that results are not guaranteed. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

______________________________	______________________________
Client's signature	Chiropractor's signature
______________________________	______________________________
Client's name (print please)	Date

Consent for use and disclosure of personal health information

We collect information from you so we can assess, diagnose and manage your health properly and be proactive in your care. We use the information in the following ways:

Administration purposes and billing in compliance with Health Insurance, Medicare and DVA as and if required. Disclosure to others involved you your health care, including doctors outside this practice whom may be involved in treating you. Disclosure to other Doctors in the practice, locums and students etc. attached to the practice for the purpose of client care and teaching. For research and quality assurance activities (this does not identify you in any way) to improve individual, community health care and practice management. Disclosure to others for medical defence or legal purposes, if necessary.

I have read the above and understand why information collection is necessary. I am aware that is Practice has a privacy policy on handing client information.

Signature: ____

Name: ____ Date: ___________________

Case #________________ Name_________________________ Dr__________________

CHIROPRACTIC INTAKE & HISTORY

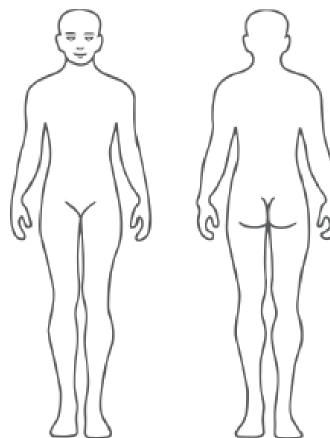
What brings you in today?

Please list your health concerns	Pain 1/10 10 is worst	Time frame of symptoms	Have you had before	How Long Ago
1.	/10		Y / N	
2.	/10		Y / N	
3.	/10		Y / N	
4.	/10		Y / N	

WHAT DOES THE PAIN FEEL LIKE?

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other___________

On the diagram to the right please circle areas
Where you have pain or other symptoms



IMPACT OF YOUR SYMPTOMS

How are these symptoms interfering with your life?(Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Relationship	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Work	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-care	☐	☐	☐	☐	Other	☐	☐	☐	☐

If we are able to help you, how committed are you to correcting this/these issues?
0/10 not very committed, 10/10 very committed. ___/10.

CHILDREN & PREGNANCY

How many children do you have? _______
Childrens' ages? _____________________
Childrens' health ? ___________________
____

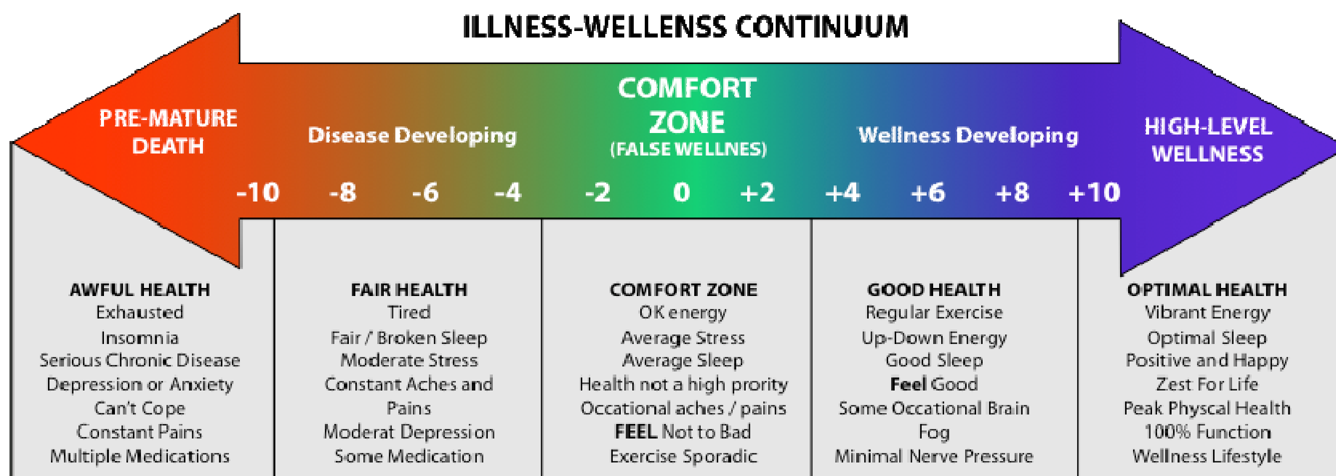
Are you currently pregnant? ☐ No ☐ Yes
Due date? ____________________________
Any concerns with this pregnancy? ________
____

PAST INJURIES & SURGERIES

INJURIES_______________________________
____
____

SURGERIES _____________________________
____
____

Case #________________ Name_________________________ Dr__________________



On the arrow diagram above:

1. What number do you think currently represents your health today?________________________
2. In what direction is your health currently going?____

What are you health goals?

Immediate____

Short term____

Long Term____

HEALTH & ILLNESS HISTORY

- ☐ AIDS/HIV
- ☐ Arthitis
- ☐ Anxiety
- ☐ Ateriosclerosis
- ☐ Constipation
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Sleep Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Elbow/Wrist/Hand
- ☐ Endocrine Issues
- ☐ Foot/Ankle Issues
- ☐ Fatigue
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues/Colds
- ☐ Pins & Needles
- ☐ Neck Pains
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Osteoporosis
- ☐ Other___________

____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS	SUPPLEMENTS
__________________________	_________________________	_________________________
__________________________	_________________________	_________________________
__________________________	_________________________	_________________________

Anything else you feel you need to tell us?____

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