Welcome to Family Chiropractic Care

Please take time to fill out this form as completely as you can. All details given here are for confidential use within the clinic. If you have questions, please do not hesitate to ask. We look forward to working with you in maintaining your health.

NAME: _____ _____ _____ Preferred Name: _____
(FIRST) (MIDDLE INITIAL) (SURNAME)

ADDRESS : _____ SUBURB: _____ Postcode: _____

TELEPHONE: _____ EMAIL: _____ ☐ Tick here if you DO NOT want to receive our E-News

DATE OF BIRTH: _____ / _____ / _____ OCCUPATION: _____

EMERGENCY CONTACT: Name _____ Relationship _____ Telephone _____

DO YOU HAVE PRIVATE HEALTH THAT COVERS CHIROPRACTIC CARE: ☐ Yes – Insurer _____ ☐ No ☐ Not Sure

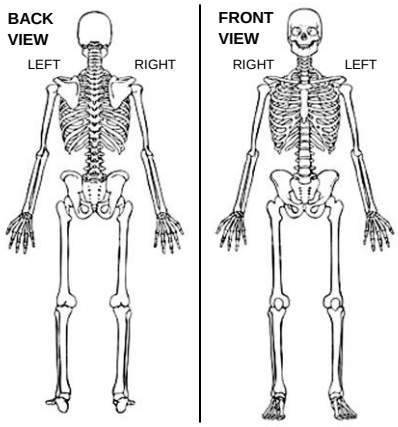
WORK COVER DETAILS (if applicable): Referring Doctor _____ Claim No. _____

HOW DID YOU FIND US: ☐ Signage ☐ Yellow Pages On-line ☐ Google ☐ TrueLocal ☐ Facebook ☐ Family Chiro website

☐ Another Patient / Referral (If so whom:_____) ☐ Any other _____

_____

Reason for this visit:



WHAT IS YOUR REASON FOR **THIS VISIT**? _____

_____

If known WHAT WAS THE CAUSE? _____

_____

IF YOU HAVE PAIN, WHAT IS THE FREQUENCY OF PAIN: _____

DESCRIBE LOCATION OF THE PAIN or INDICATE ON THE DRAWING:

_____

_____

WOULD YOU DESCRIBE THIS PAIN AS: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____

ARE YOU EXPERIENCING: ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Cramping ☐ Tingling ☐ Spasms

ARE ANY OF THE FOLLOWING DIFFICULT/PAINFUL: ☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Running/Jogging
☐ Lying down ☐ Lifting ☐ Other _____

APPROX. DATE SYMPTONS BEGAN? _____ HAVE YOU HAD SIMILAR SYMPTONS BEFORE ☐ Yes ☐ No

IS THE PAIN GETTING: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes

HAVE YOU BEEN TREATED BY A HEALTH CARE PRACTIONER FOR THIS CONDITION BEFORE TODAY? ☐ Yes ☐ No

IF YES WHAT TYPE: ☐ Medical Doctor ☐ Chiropractor ☐ Physiotherapist ☐ Masseuse ☐ Other _____

HAVE YOU HAD A SPINAL X-RAY OR CT SCAN DONE? ☐ Yes - If so, when _____ ☐ No ☐ Can't remember

_____

If you have ever had Chiropractic care before, please complete the following:

NAME OF CHIROPRACTOR: _____ LOCATION: _____

WHAT WERE YOU BEING TREATED FOR? _____

No. OF TREATMENTS PROVIDED? _____ HOW OFTEN? _____ WHEN WAS YOUR LAST TREATMENT? _____

~ PLEASE ALSO COMPLETE OTHER SIDE ~

Health History:

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE, ANY OF THE FOLLOWING MEDICAL CONDITIONS:

☐ Migraine	☐ Neck pain	☐ Lower back pain	☐ Heart attack	☐ Cancer
☐ Dizziness	☐ Shoulder pain	☐ Leg pain	☐ Stroke	☐ Asthma
☐ Epilepsy	☐ Arm pain	☐ Sciatica	☐ High Blood Pressure	☐ Other _____
☐ Diabetes	☐ Arthritis	☐ Scoliosis	☐ Artificial joints/limbs	_____

PLEASE LIST ANY MEDICATION (INCLUDING PAIN KILLERS) YOU ARE TAKING: _____

_____

_____

PLEASE LIST ANY SERIOUS INJURIES OR SURGERIES YOU HAVE HAD:

☐ Falls Date:_____ Details:_____

☐ Head Injuries Date:_____ Details:_____

☐ Broken Bones Date:_____ Details:_____

☐ Dislocations Date:_____ Details:_____

☐ Surgeries Date:_____ Details:_____

☐ Other Serious Injuries Date:_____ Details:_____

_____

Exercise & Sports:

What sporting and exercise activities do you partake in: _____

How would you classify your exercise or sporting level: ☐ Social ☐ For fitness ☐ Amateur ☐ Semi-Professional ☐ Professional

_____

Women only:

Are you pregnant? ☐ Yes – if so how far along are you _____ months _____ weeks ☐ No ☐ Not sure

_____

Patient Information on Chiropractic Care:

Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug free health care profession in the world. However, as in all health care there are some possible risks that may be associated with chiropractic care. This includes but is not limited to: Your condition becoming worse; Disc injuries, rib fractures, sprains/strains (1 in 139,000 in the neck, 1 in 62,000 in the low back); Stroke or stroke like symptoms (1 in 5.85 million in neck adjustments). Some people may experience mild muscle soreness for 24 – 48 hours after their first one or two adjustments – this is a normal sign of change, as may occur after exercise or stretching. Put into context chiropractic has been shown to be 250 times safer than anti-inflammatory drugs and safer than driving a car. Studies also indicate that 23% of people experience an *unexpected improvement* in other aspect of their health such as: easier to breath, improved digestion, clearer vision, better circulation, improved blood pressure.

If you have any questions relating to the care you are about to receive, please speak to your chiropractor.

_____

Informed Consent:

I acknowledge the above information and do not expect the chiropractor to be able to anticipate all potential risks and complications. I understand that results are not guaranteed. I have reviewed the information I have provided and believe it to be accurate. I understand that this information will be used by the clinic to help determine appropriate treatment. If there are any changes in my medical status I will inform the clinic. I hereby consent and request chiropractic adjustments and procedures as the chiropractor determines necessary. By signing below I agree to receive chiropractic care in this clinic and I intend this consent form to cover the course of my chiropractic care for this and future presentations.

ACA AUSTRALIAN CHIROPRACTORS ASSOCIATION MEMBER

Family Chiropractic Care

_____ _____ _____

Patient's Name (please print) Signature (or Guardian Signature) Date