Transformation CHIROPRACTIC

QUESTIONNAIRE

YOUR DETAILS

NAME: Title _____ First Name _____ Surname _____

GENDER: ☐ Male ☐ Female Date of Birth: ____ / _____ / _____ Age: _____

POSTAL ADDRESS: _____

Suburb _____ State _____ Postcode _____

TEL NUMBERS: Home _____ Mobile _____ Work _____

PREFERRED TEL: ☐ Home ☐ Mobile ☐ Work

EMAIL ADDRESS: _____

OCCUPATION: _____

EMERGENCY CONTACT: Name_____ Number_____ Relationship_____

WE APPRECIATE REFERRALS. HOW DID YOU FIND OUT ABOUT OUR CLINIC?

☐ Family member ☐ Another Health Professional ☐ Online ☐ Our Signage

☐ Friend, please specify: _____

PRESENT STATE OF HEALTH

Major symptom/problem: _____

Pain / Problem started on: _____ triggered by: _____

Have you had previous episodes of this problem? ☐ No ☐ Yes Number of Times: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is the pain referring to other areas of your body? ☐ No ☐ Yes: Where? _____

Is condition getting better? ☐ No ☐ Yes

What brings on your condition or makes it worse? _____

What relieves your condition or makes it feel better? _____

DAILY ACTIVITIES

Do you exercise? ☐ Daily - Weekly ☐ Occasionally ☐ Never

Do you smoke? ☐ No ☐ Yes: _____per day

With regards to any drugs/medication you currently or have recently used, please list:

Drug/medication Names	Dosage	Reasons for use

Have you received chiropractic care before? ☐ No ☐ Yes

If yes, when was your last visit? _____

Have you ever had any spinal X-rays taken? ☐ No ☐ Yes. When? _____

Which spinal areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

MEDICAL HISTORY

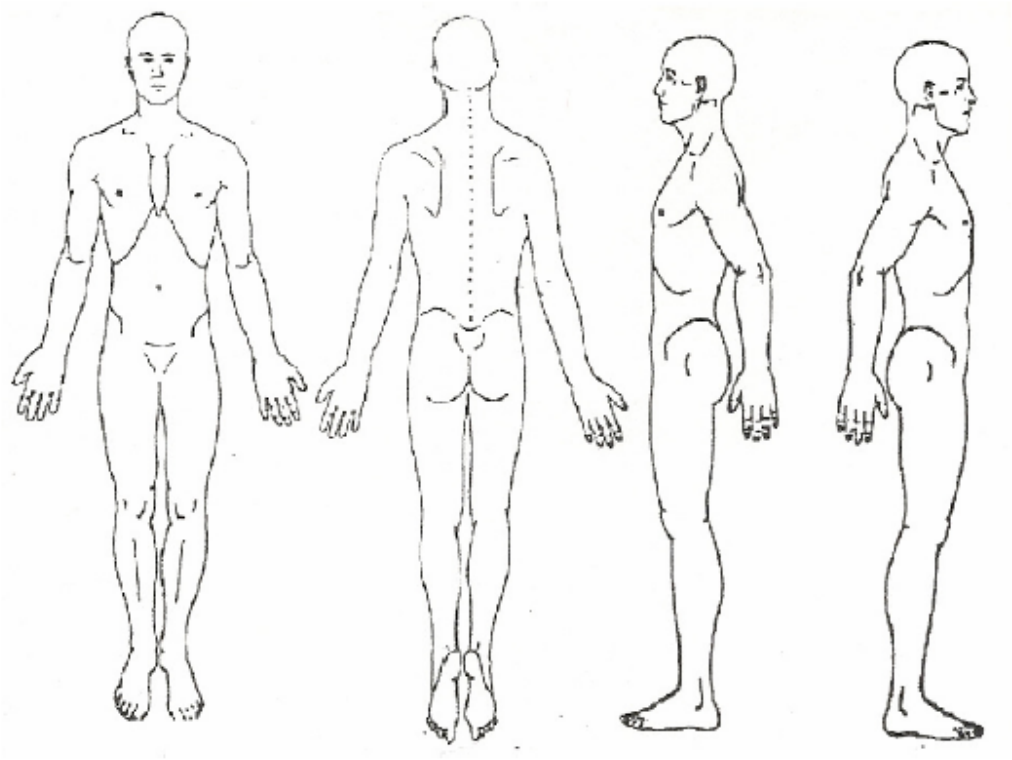
Please include any Hospitalisations, Child Deliveries, Surgery, Serious Accidents, Major Dental work, Fractures and Dislocations:

_____

_____

_____

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -



PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence.
However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also, when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Patient's Signature: _____

Date: _____

PATIENT INFORMATION

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatment of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. (Current literature states this to be approximately 1 in 1-2 million according to D. Chapman-Smith, seminar 2002 and approximately 1 in 5.85 million neck manipulations according to Haldeman, et al, Spine vol. 24-8 1999).

Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000).

Chiropractic adjustments (manipulations) 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, 1995. Manga Report, Ontario Ministry of Health, 1993).

Please note that this consent does not waiver your Common Law Rights, rather it is merely for you to acknowledge that you have been informed of the known risks.

If an appointment must be changed, 24 hours notice is appreciated. A full fee amount will be charged to clients who do not cancel or reschedule within the critical notification time frame. This policy is critical to ensure your momentum continues and gained benefit is not lost.

If you have any questions related to the treatment you are about to receive or possible alternative approaches, please speak to the chiropractor.

I have discussed the above information with the chiropractor and give my consent to treatment.

Patient's Signature: _____ Print Name : _____

Chiropractor's Signature : _____ Date : _____