New Patient Registration Form

Date / /

YOUR DETAILS

NAME: Title ________ First Name ___________________________ Surname _________________________________

DATE OF BIRTH: ____/____/_____

ADDRESS: ____

Suburb____State_________________Postcode __________

POSTAL ADDRESS: ____

Suburb____State_________________Postcode __________

PHONE NUMBERS: Home_____________________________Mobile______________________________Work ____________________

EMAIL ADDRESS: ____

Do you wish to receive marketing emails? No ☐ Yes ☐

SPOUSE / PARTNERS NAME: ____ CONTACT ____________________

ARE YOU A MEMBER OF A PRIVATE HEALTH FUND?

☐ No ☐ Yes - Fund Name: ____________________ Member # ____________________________

ARE YOU A CONCESSION CARD HOLDER? No ☐ Yes ☐

Type of concession? ____________ Card # __________________________

Medicare No: __________________________________ Ref # ____ Expiry ______________

OCCUPATION: ____

IF RETIRED OR UNEMPLOYED, YOUR PREVIOUS OCCUPATION: ____

WHO IS YOUR GP? ______________________________ GP LOCATION _____________________________________

WE APPRECIATE REFERRALS. HOW DID YOU FIND OUT ABOUT OUR CLINIC? (friend, family, sign, internet etc)

Name of Referrer / Detail ____

Please complete all 4 pages.

Read & discuss page 5 & 6 with your chiropractor

PRESENT STATE OF HEALTH

Our patients often present to us with more than one symptom / condition. The more information we have, the better we can help you. Please describe your major symptoms below in as much detail as possible as well as any other problems / symptoms you are experiencing.

1. 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 worse? ☐ No ☐ Yes

What brings on your condition or makes it worse? ______________________________

What relieves your condition or makes it feel better? ______________________________

Is this symptom/condition interfering with any activity (please specify) ______________________________

____

2. Major symptom/problem (if more than one): ______________________________

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 worse? ☐ No ☐ Yes

What brings on your condition or makes it worse? ______________________________

What relieves your condition or makes it feel better? ______________________________

Is this symptom/condition interfering with any activity (please specify) ______________________________

____

3. Any other symptoms / problems: ______________________________

____

Have you seen other Doctors/Practitioners seen for these conditions? ☐ Yes ☐ No

If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other

Please list any previous treatment employed successful or unsuccessful : ______________________________

What are your long-term goals and expectations of care? eg play golf again, play with kids, more energy etc

____

____

What are your sleep patterns like?____

____

What are your overall stress levels? (out of 10) ______________________________

What is your biggest stressor? ____

Please tick if you have had any of the following symptoms in the last 30 days:

☐ Pain worse at night ☐ Loss of bowel or bladder control ☐ Constant pain unrelated to movement

☐ Bacterial infection ☐ Fever and/or chills ☐ Unexplained weight loss

Please tick if any of these are relevant to you

☐ History of cancer ☐ Are you pregnant ☐ Do you have a pacemaker ☐ Do you have epilepsy

Please list your current or recent medications

Drug/medication Names	Dosage	Reasons for use

Have you received chiropractic care before? ☐ No ☐ Yes

If yes, when and where was your last visit? ______________________________

Were you pleased with the service provided? ______________________________

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

PAST HISTORY

Have you been treated for any health conditions in the last year? ☐ No ☐ Yes - explain:__________________

Please list all hospitalisations and surgeries: ______________________________

Any previous Diagnoses: ______________________________

Have you ever had any injuries or accidents? ☐ No ☐ Yes - explain: ______________________

Have you had one or more falls in previous year? ☐ No ☐ Yes - How many? ______

Do you have any problems with your heart or lungs? ☐ No ☐ Yes - explain: ______________________

Do you have any problems with your urinary system? ☐ No ☐ Yes – explain: ______________________

Do you have any problems with your stomach, intestinal systems? ☐ No ☐ Yes - explain:______________________

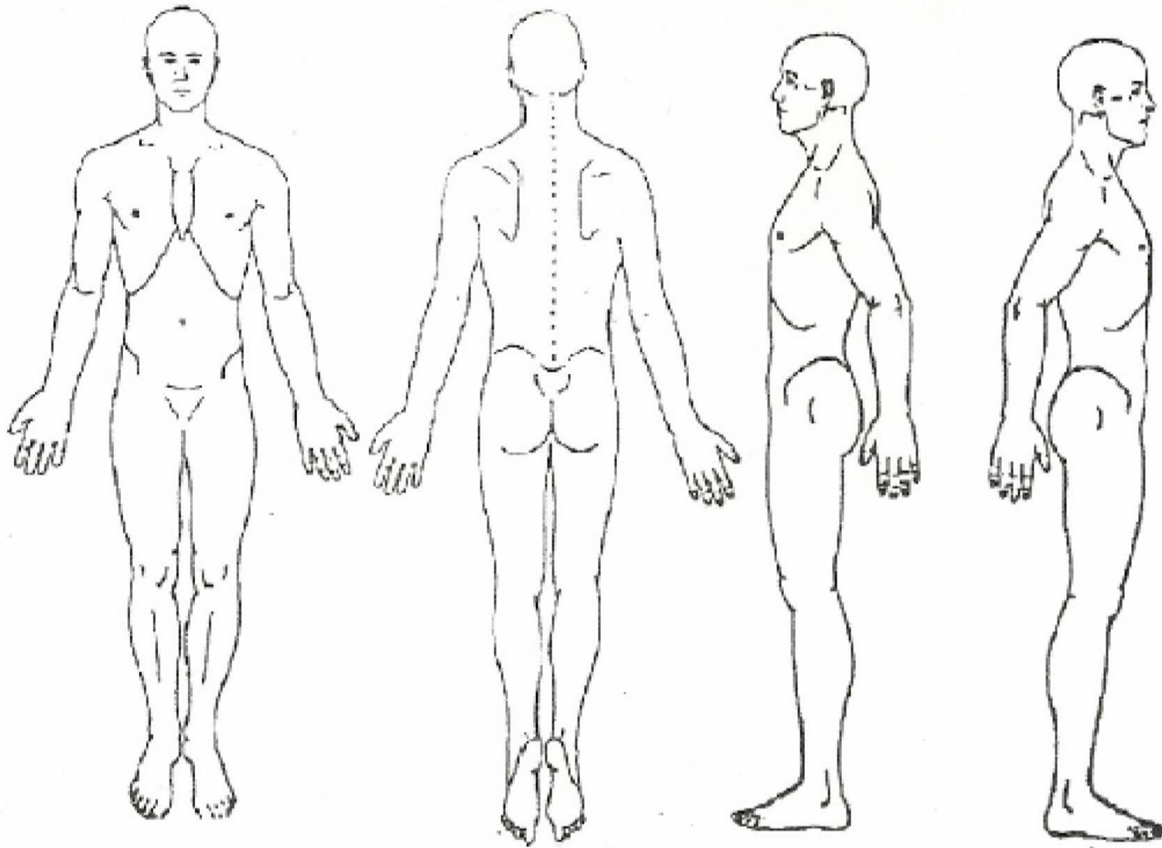
Do you have any gynecological or reproduction issues? ☐ No ☐ Yes – explain: ______________________

Do you have any other organ or skin issues? ☐ No ☐ Yes – explain: ______________________

Do you currently suffer any dizziness or vertigo? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes – how many per day? ______________________

Please mark the diagram below where your complaint areas are



Risks Associated with Chiropractic Procedures Form

Please read this form. Your Chiropractor will discuss it with you and ask you to sign a 'Consent to Chiropractic Care Form' prior to any treatment being given.

Your Chiropractor will discuss details of your diagnosis and management of your condition. You are encouraged to ask questions about the treatment proposed, terminology used or treatment options available to you.

Chiropractic treatment, including spinal manipulation or adjustment, has been the subject of many government reports as well as multi-disciplinary studies. Chiropractic has been shown to be a safe, effective treatment for spinal pain, some headaches and similar symptoms.

The risk of injuries or complications from chiropractic treatment is lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms. The purpose of this document is to provide you with the information necessary to consent to treatment, including spinal manipulation.

Possible Adverse Outcomes:

1. In a minority of cases, treatment may not be successful and you may be in the same position you are in now.

2. Uncommonly, your condition may become worse:
   - About 1 in 3 patients may report temporary soreness, tenderness/bruising
   - Some patients report fatigue, headache, dizziness or nausea following treatment. These symptoms usually resolve within 24 hours after treatment.
   - While rare, some patients have reported rib pain, shoulder pain, chest pain and knee pain following manipulation. These symptoms usually resolve within 2 days after treatment.
   - There is a slight risk of other injuries including strain/sprain to a ligament or disc in the neck or lower back. These are rare but can cause nerve pain with radiation of pain into arms, trunk or legs (current statistics neck less than 1 in 139,000 and the low back 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). Bowel or bladder function can be affected and erectile disfunction has been reported very rarely.
   - In the case of manipulation or adjustment of the neck, there have been reported cases of injury to arteries in the neck. These are very rare events (current statistics between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

3. Although we have asked screening questions and performed screening tests, there is no way of guaranteeing that you will not suffer one of these extreme rare events.

4. If imaging is required, it is generally understood that no x-ray exposure is without some risk; however, there is no conclusive evidence of radiation causing harm at the levels you would receive from this proposed diagnostic x-ray exam. Although high doses of radiation are linked to an increased long term risk of cancer, the effects of the low doses of radiation (ie, less than your yearly exposure to natural background radiation) used in diagnostic imaging are not known. Any proposed examination would have been determined clinically necessary as part of your care and every precaution is taken to ensure the lowest radiation exposure is applied to achieve the clinical purpose.

5. If you experience any unexpected signs or symptoms after treatment such as nausea, vomiting, visual disturbances, difficulty speaking or balance problems, please seek medical attention immediately. During office hours, please call the clinic.

Please direct any questions to your treating Chiropractor

CONSENT TO CHIROPRACTIC CARE FORM

I,

____

Patient Name – please print

have consulted ____

Chiropractor's Name – please print

With the following: ____

Presenting complaint (s)

I have been advised that appropriate management may include the following:

Chiropractic Manipulative Therapy (CMT) *Circle region: Cervical /Thoracic /Lumbo-pelvic/Full Spine.* *Extremity: list …………………………………………………………….*	☐	**Soft Tissue Therapy** *(Circle: instrument assisted / myotherapy / muscle stretches / trigger point release.*	☐
Mobilisations/Traction/Flexion Distraction/Drop piece / Gravitational blocking /Activator *Circle region: Cervical /Thoracic /Lumbo-pelvic/Full Spine.* *Extremity: list …………………………………………………………….*	☐	**Taping:** *Circle: Rigid / Elastic / Kinesio*	☐
Heat/cold therapy	☐	**Rehabilitation exercises** (incl. core strengthening, dynamic stabilization, postural re-training, balance and proprioception training)	☐
Other treatment modality: ……………………………………………………………………………….	☐	**Active lifestyle advice** (reassurance, diet, exercise) ………………………………………………………………………………	☐
I do NOT consent to the following treatment:			

- I acknowledge that the treatment modalities I give consent to above, may be administered by any Chiropractor in this clinic that I choose to see.
- I have had the opportunity to discuss the diagnosis, nature and purpose of Chiropractic management with my Chiropractor.
- I have been advised of alternatives and options to me including that of receiving no treatment.
- I have read and discussed the accompanying "Risks Associated with Chiropractic Care form over leaf, in particular those risks that are relevant to my case.
- I have had explained to me any terms in the "Risks Associated with Chiropractic Care" form that I did not understand.

These terms (if any) were: ……………………………………………………………………………………...............................

I understand the nature and extent of the risks and I voluntarily accept all risks involved. I also understand that I can qualify or withdraw my consent at any time. This consent does not prevent me seeking damages for injury caused by negligent treatment.

Patient's Signature (or legal guardian): ______________________________ Date: _______/________/________

Chiropractor's Signature: ____Date: _______/________/______