Coast Health & Chiropractic

YOUR DETAILS Date: ____ / ____ / ____

NAME: Title _____ First Name _____ Surname _____

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

ADDRESS: _____

Suburb _____ State _____ Postcode _____

POSTAL ADDRESS: ☐ *As Above* _____

Suburb _____ State _____ Postcode _____

TEL NUMBERS: Home _____ Mobile _____ Work _____

EMAIL ADDRESS: _____

IS THIS A THIRD PARTY, WORKERS COMPENSATION OR CAR ACCIDENT CLAIM?

☐ No ☐ Yes - Insurer Details: _____

_____

IS YOUR CHIROPRACTIC CARE COVERED BY VETERAN AFFAIRS OR MEDICARE ENHANCED PRIMARY CARE (EPC)?

☐ No ☐ Yes (Please present your referral form to us)

GP NAME AND SUBURB _____

OCCUPATION: _____

IF RETIRED OR UNEMPLOYED, YOUR PREVIOUS OCCUPATION: _____

FAMILY MEMBERS: Name(s) of other Family members (s) Age(s) of other Family member (s)

_____ _____

_____ _____

_____ _____

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

☐ Our Signage ☐ Our Website

☐ Yellow Pages - ○ *Online* ○ *Book*

☐ Internet Search Engine, please specify: _____

☐ Another Health Professional, please specify: _____

☐ Friend, please specify: _____

☐ Family member, please specify: _____

☐ Other, please specify: _____

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PAST HISTORY

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

When were you last in hospital and what for? _____

In the past have you had any surgery? ☐ No ☐ Yes - explain: _____

_____

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

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

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

_____

_____

Do you have any problems related to your menstrual cycle? ☐ No ☐ Yes - explain:

_____

_____

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

_____

Do you smoke? ☐ No ☐ Yes, if yes how many per day _____/day

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 ☐ Surgery ☐ Fever and/or chills ☐ Unexplained weightloss

Please tick if you have any of the following:

☐ History of cancer ☐ History of HIV ☐ Use of steroids ☐ Use of IV drugs ☐ Blood transfusions

☐ Other previous serious illness _____

With regard to any drugs you currently or have recently used, please list:

Drug/medication Names	Reasons for use

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PAST HISTORY

Have you received chiropractic care before? ☐ No ☐ Yes

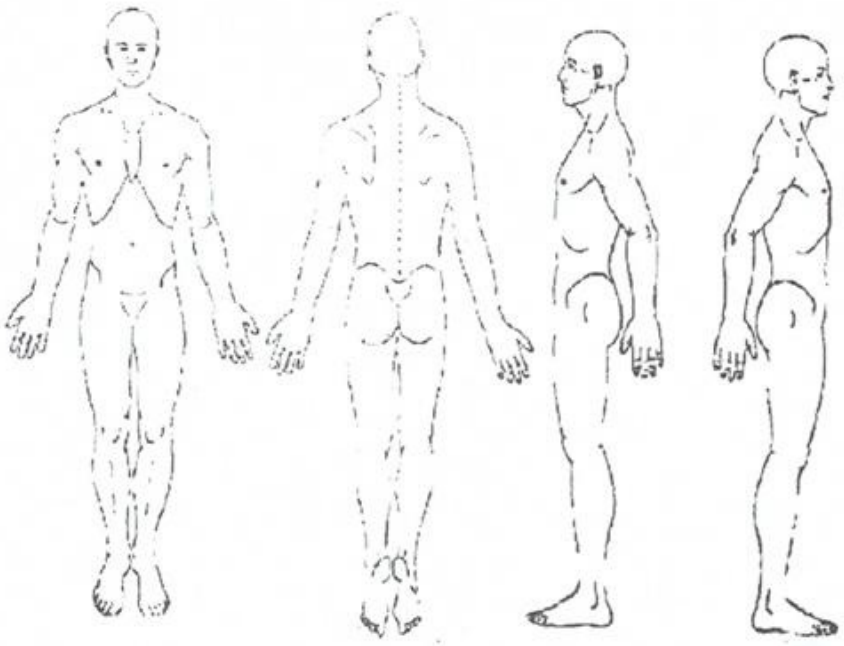
If yes, when was your last visit? _____

Were you pleased with the service provided? _____

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

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

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



FAMILY HISTORY

Do you have a family history of any medical problems? ☐ No ☐ Yes. _____

_____

_____

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PRESENT STATE OF HEALTH

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

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: ☐ Work ☐ Sleep ☐ Routine

☐ Other (please specify) _____

Have you seen other Doctors/Practitioners seen for this condition? ☐ No ☐ Yes

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

Please list any home remedies employed: _____

_____

Other problems you are concerned about: _____

_____

_____

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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. Your chiropractor will discuss with you any specific risks pertinent to your case should any indicators of risk arise during your consultation.

I have read this form and understand the information it contains. I will ask questions openly and directly. I have disclosed all relevant information regards my medical history and I understand that I will be treated accordingly to the information I have disclosed. I give my full consent to treatment.

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 _____