



Client details

Date _____ Case no. _____

Master/Miss First name _____ Last name _____

Preferred name _____

Date of birth _____ Age _____

Parent/s names _____

Current address _____

PO Box _____

Phone Home _____ Mobile _____ Work _____

Email _____

Private Health Fund _____

Recommended to us by

☐ Another Client Name _____

☐ Internet search ☐ Radio Advertising ☐ Billboard ☐ Facebook

☐ Yellow Pages ☐ Signage ☐ Other _____

Preferred contact method ☐ SMS ☐ Phone call - home/mobile

Reminder ☐ Yes ☐ No

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-Haldeman, 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

Child's name (print please)

Date

Consent for use and disclosure of personal health information

We collect information (which may include photographs/video) 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 in your health care, including Doctors/Allied Health Professionals 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: _____

Child's Name: _____ Date: _____

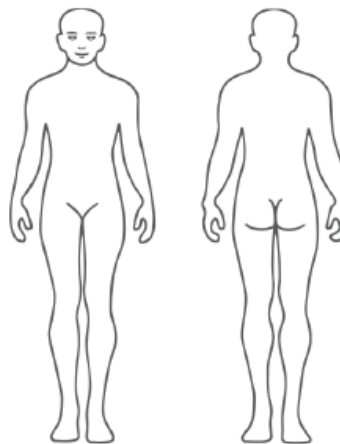
CHIROPRACTIC INTAKE & HISTORY

WHAT BRINGS YOU IN TODAY?

Please list your health concerns OR where it hurts	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 | ☐ Sharp |
| ☐ Tingling | ☐ Shooting |
| ☐ Stiffness | ☐ Burning |
| ☐ Dull | ☐ Throbbing |
| ☐ Aching | ☐ Stabbing |
| ☐ Cramping | ☐ Swelling |
| ☐ Nagging | ☐ 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? (Tick the box where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Relationship	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Work	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Sports	☐	☐	☐	☐	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 living at home? _____

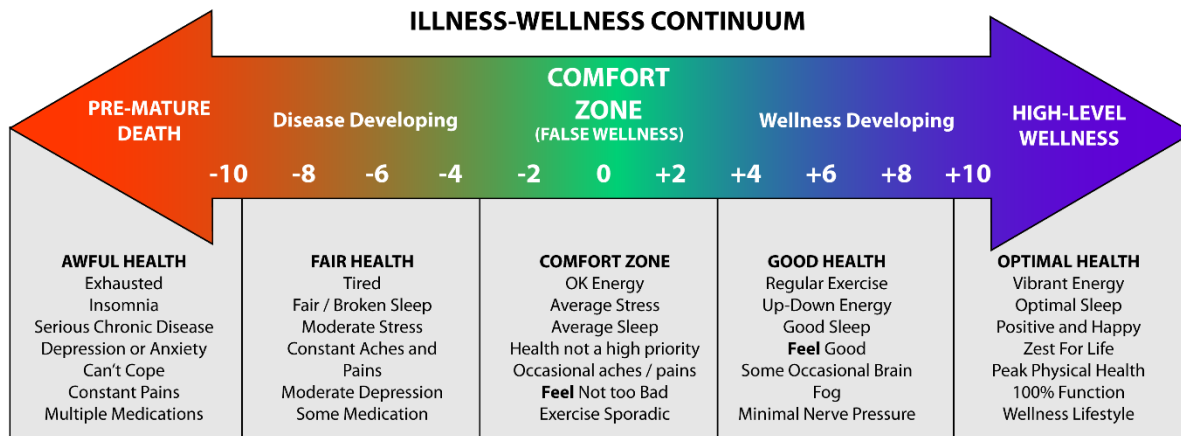
Childrens' ages? _____

Childrens' health ? _____

Are you currently pregnant? ☐ No ☐ Yes

Due date? _____

Any concerns with this pregnancy? _____



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 YOUR HEALTH CARE GOALS?

- Immediate ☐ just get out of pain
- Short Term ☐ get out of pain, back to my comfort zone and stop it returning
- Long Term ☐ optimal health, be the best me

HEALTH & ILLNESS HISTORY

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES

MEDICATIONS

SUPPLEMENTS

Anything else you feel you need to tell us? _____
