Personal Details

DATE: _____

PATIENT NAME: Dr / Mr / Mrs / Ms / Master / Miss _____

BIRTHDATE: _____ PARENT / CARER'S NAME: (if applicable) _____

ADDRESS: _____ SUBURB: _____

STATE: _____ POSTCODE: _____ EMAIL: _____

PHONE (H): _____ (W): _____ (M): _____

Please Note: Your mobile phone no. and email address will be kept confidential and used for appointment reminders and practice information only.

OCCUPATION: _____ NEXT OF KIN: _____

YOUR DOCTOR: _____ Location: _____

Are you covered for chiropractic care with a Private Health Fund? Yes / No If yes, name of fund? _____

Is this related to a Workers Compensation / Third Party / Accident / Insurance / DVA Claim? (Please circle)

If yes, claim / card no: _____

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? Yes / No (Don't worry! We will explain everything as we go and only proceed once you are completely comfortable).

Please complete the following information as accurately as possible.

Major Complaint

What is your main problem? _____

_____

_____

When and how did it start? _____

_____

Was there any of the following prior to or during the onset? (Please circle)

Illness / Infection / Trauma / Other significant event _____

Are your symptoms worse at night or any specific time of the day? Yes / No Time? _____

Are your symptoms getting worse? Yes / No _____

Do you have any pain traveling down your arms or legs? Yes / No If yes, describe:

_____

What relieves your symptoms? _____

What makes your symptoms worse? _____

Have you had any other treatment for your current problem? Yes / No _____

Does your current problem involve any of the following? If Yes, where?

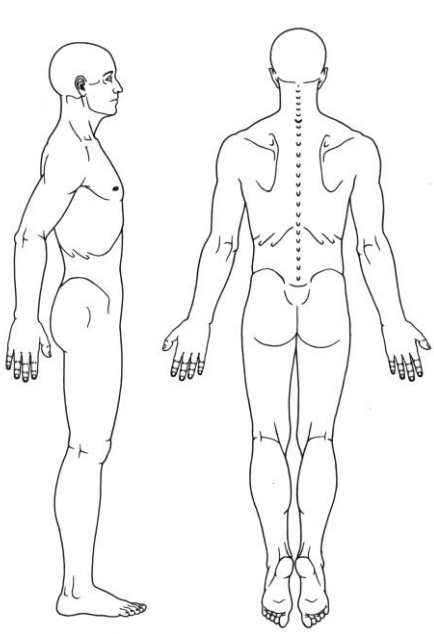
Tingling in either arm or leg? Yes / No _____

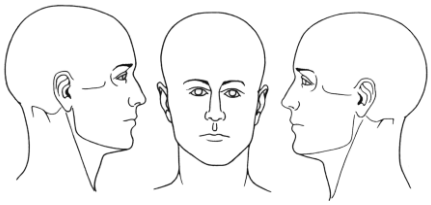
Numbness in either arm or leg? Yes / No _____

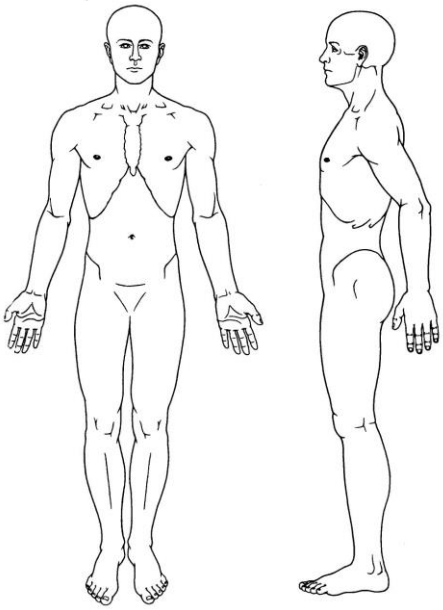
Weakness in either arm or leg? Yes / No _____

'Weird' sensations in either arm or leg? Yes / No _____

Please mark on the diagrams below any areas of discomfort, numbness, pins and needles or concern.







Medical History & General Health

Please circle: Details:

Did you / Do you smoke? Yes / No _____

Did you / Do you drink alcohol? Yes / No _____

Did / Do you take recreational drugs? Yes / No _____

Do you think you have a poor diet? Yes / No _____

Do you take vitamin supplements? Yes / No _____

Do you exercise regularly? Yes / No _____

Have you had any form of surgery? Yes / No _____

Are you currently taking *any* form of medication? Yes / No If yes, list all of them _____

_____

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No _____

Have you had any broken bones? Yes / No If yes, which ones and how? _____

_____

Have you had any car accidents (no matter how trivial)? Yes / No If yes, when and describe _____

_____

Have you had any falls or sports injuries? Yes / No If yes, when and describe _____

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No _____

Do you suffer from fatigue? Yes / No _____

Have you had any persistent change in your appetite during the last three months? Yes / No _____

Has your weight changed more than ten pounds (4 Kg) in the last year? Yes / No _____

Have you noticed any blood or mucus in your bowel movements? Yes / No _____

Do you get pain in any of your joints? Yes / No _____

If yes, is it worse in the night? Yes / No _____

Do your joints ever swell? Yes / No _____

Do you wake up with stiffness or aching in your joints or muscles? Yes / No _____

Do you have any problems with hearing (including ringing in the ears)? Yes / No _____

Did you / Do you have occupational stress? Yes / No _____

Does stress seem to make your main problem worse? Yes / No _____

How would you rate your levels of anxiety? High / Medium / Low / Very Low

How would you rate your levels of depression / low mood? High / Medium / Low / Very Low

How would you rate the quality of your sleep? Good / Satisfactory / Poor / Very Poor

Are you often troubled by headaches? Yes / No _____

If yes: Are they accompanied by sickness or other symptoms? Yes / No _____

Do you have any problems with your vision? Yes / No _____

Have you any lumps, cysts, or unusual swellings anywhere on your body? Yes / No _____

Do you get twitching or cramping anywhere? Yes / No _____

Do you have poor balance? Yes / No _____

Did you / Do you suffer vertigo? Yes / No _____

CANCELLATION POLICY

We are a very busy clinic and often have patients on a waiting list. You will receive a reminder SMS or email the day before your appointment, in the afternoon. Please call us immediately if you are no longer able to attend. We are more than happy to change appointments for you as needed, but require at least 2 hours notice.
A late cancellation fee of $20 will apply within 2 working hours of your appointment time.
The full consultation fee will apply if your appointment is not cancelled. **Initial _____**

PATIENT INFORMATION / MEDICAL CONSENT / PRIVACY POLICY

Aligned Chiropractic specialises in treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate. In accordance with the 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 and therapists, or, when appropriate, with other medical and healthcare practitioners for the proper and effective management of your condition.

All practitioners who manipulate the spine are required by law to warn patients of material risks, as are all registered health practitioners. In extremely rare circumstances, some treatments 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 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 to minimise any risk, 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 low back (1 in 62,000).

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

I hereby consent for clinical information to be communicated to my health / general practitioner where appropriate and indicate that I have been informed of any relevant risks associated with Chiropractic care.

_____
(Signature)

How did you find us?

(Feel free to tick as many sources as relevant)

SOMEONE TOLD ME ABOUT YOU
- ☐ A patient of yours referred me.
  Who? _____
- ☐ My GP referred me.
- ☐ Someone else referred me.
- ☐ Another health practitioner referred me.
  Who? _____

IN THE BOOK
- ☐ Yellow pages book.
- ☐ White pages book.
- ☐ Local Directories book.

ONLINE
- ☐ Google search / Google plus page.
- ☐ Online search sent me to your website.
- ☐ Facebook.
- ☐ Yellow pages online.
- ☐ Local Directories online.
- ☐ White pages online.

AROUND
- ☐ I saw the street signage.
- ☐ Through the *Rocky River Run* advertising.
- ☐ I came here a long time ago.

- ☐ OTHER
  _____