ALIGNED CHIROPRACTIC

Given name: **Surname:**

Address:

Emergency contact: **Relationship to patient:**

Date of birth: **Email:**

Mobile phone: **Home:** **Work:**

Occupation (if retired, former occupation):

Private health fund: **yes / no** **Which fund?**

How did you hear about us?

☐ **Friend/Family member** ☐ **Google search**

☐ **GP/Health practitioner** ☐ **Yellow pages**

☐ **Local directories** ☐ **Our website** ☐ **Signage/Passing by** ☐ **Other:**

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 particular issues and assist your body in the healing process. 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 please describe them as clearly as you can by answering the following:

Major problem/symptom

When did the problem start? **How did it start?**

Have you had this problem before? **Yes / No** **How often?**

Pains are: ☐ **Sharp** ☐ **Dull** ☐ **Constant** ☐ **Intermittent**

Is the pain referring to other areas? **Yes / No** **If so, where?**

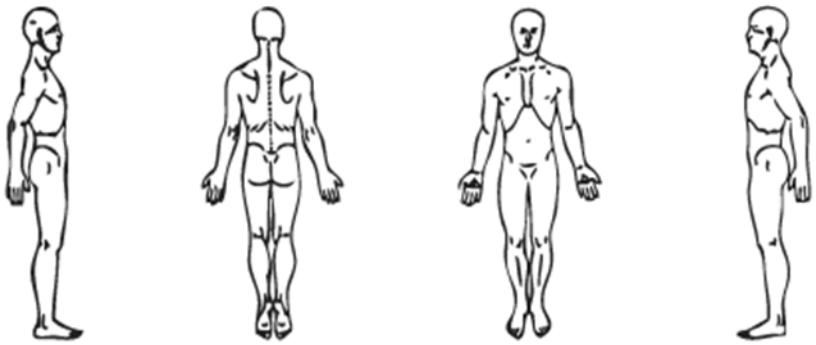
Is the condition getting worse? **Yes / No** **Is the problem disrupting normal activities?** **Yes /No**

What other treatment have you had for this condition?

What aggravates your problem?

What helps or relieves your problem?

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



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How does this condition affect the quality of your life in regards to: (0=doesn't affect 10=affects severely)

Partner_____ Recreation _____ Social_____ Work_____Family_____ Friends_____

What have you done to help the issue on your own that has not yet given you a permanent result?

☐ Exercise ☐ Medication ☐ Heat ☐ Diet ☐ Lifestyle changes ☐ Other _____

What activities are involved in a typical day for you?

☐ Driving ☐ Desk/Computer work ☐ Physical labour ☐ Long work hours ☐ Repetitive tasks

How stressful or physically demanding is your job?_____(1= low stress/exertion 10= high stress/ exertion)

How sedentary are you throughout the day?_____

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?_____

Have you ever had any form of surgery? ☐ No ☐ Yes – explain_____

Have you ever had any injuries or accidents? ☐ No ☐ Yes – explain_____

Any problems with your heart or lungs? ☐ No ☐ Yes – explain_____

Any problems with your stomach/intestinal/urinary systems? ☐ No ☐ Yes – explain_____

Any dizziness or vertigo? ☐ No ☐ Yes

Do/did you smoke? ☐ No ☐ Yes – if yes how many?_____per day

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

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

☐ Bacterial infection ☐ Surgery ☐ Fever/chills ☐ Unexplained weight change

Please tick if you or close relatives have any history of the following:

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Low blood pressure ☐ Stroke ☐ Heart disease

☐ Anxiety/Depression ☐ Arthritis ☐ Other_____

List any current or recently taken drugs/medications:

Drug/medication name	Dosage	Reason for use

Have you had chiropractic care before? ☐ No ☐ Yes - if yes, when?_____

Have you had any spinal x-rays taken? ☐ No ☐ Yes – if yes, how long ago?_____

Which spinal areas were x-rayed? ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

Sleeping position: ☐ Back ☐ Stomach ☐ Side Age of mattress:_____ No. of pillows:_____

Females only- Are you or could you be pregnant? ☐ No ☐ Yes – How advanced?_____

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What health goals are you most interested in?

☐ Improve overall health ☐ Eliminate pain and symptoms ☐ Improve spinal strength and posture

☐ Healthier lifestyle for myself and my loved ones ☐ Gain or lose weight ☐ Health and longevity

☐ Improve immune system ☐ Sports and exercise recovery ☐ Improve nervous system health

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 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 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, I agree to the office policies and give my consent to treatment.

Patient Signature: _____ Date: _____

Chiropractor's Signature: _____ Date: _____