CHIROPRACTIC REVIEW

Name_____ DOB___/___/_____

Address_____Suburb_____P/code_____

Phone _____ Email _____

Occupation_____ Health Fund _____

We are grateful that our practice grows by referral. Who can we thank for referring you? _____

Treatment today has been sought for _____

Have you received Chiropractic Care before?

☐ Yes ☐ No (don't worry, we will explain everything & only proceed once you are completely comfortable)

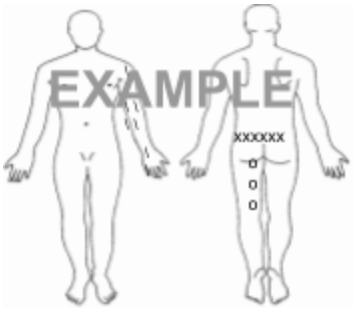
If yes: Which adjusting method do you prefer? ☐ Instrument ☐ Manual ☐ Network

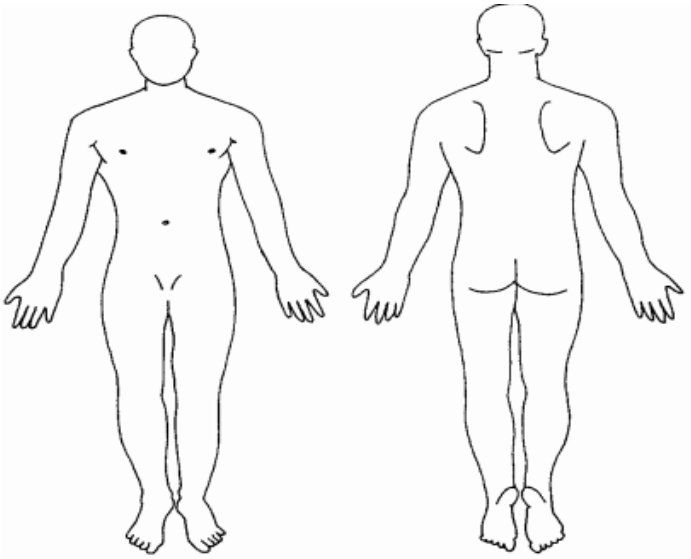
ON THE DIAGRAM please indicate:

x *(pain)* o *(numbness)*

\ *(pins and needles)* ? *(burning sensation)*

(other: _____)





Most Recent Occurrence (more questions on the very first occurrence on next page)

What caused it recently *(we need details please)*? _____

_____

_____

How long has it been there?_____ How often does it happen? _____

Is it *(circle);* getting better / worse / staying the same Is it affecting other joints? _____

What has it stopped you from doing? _____

Is it referring or radiating anywhere? Where? _____

What other problems have you noticed since it began?_____

Very First Occurrence (/ /) *estimated date*

What happened for you to first suffer from this problem (be as specific as possible)? _____

_____

_____

Since the first occurance how have the frequency & duration of symptoms changed (how often; and how long symptoms last each time)? _____

Since the very first occurrence, is it feeling: better / worse / the same? *circle*

Any radiating or referred pain changes, since first occurrence? _____

Other treatments since the first occurrence: _____

Pain Characteristics

1. *Type (circle):* Sharp Dull Aching Throbbing Stabbing Cramping Burning Other:_____

2. Severity *(circle):* (no pain) 0 1 2 3 4 5 6 7 8 9 10 (maximum pain)

3. What actions and when does it hurt *(circle):* morning midday night sitting standing it wakes me walking stairs running gym other:_____

4. What makes it better?_____

5. Does it hurt to cough/sneeze/go to the toilet? *(circle)* YES NO ... **6.** Night sweats? *(circle)* YES NO

7. Any unexplained weight loss? *(circle)* YES NO … **8.** Pain is: *(circle)* Constant Intermittent

Relevant Medical History

Please list any breaks/fractures and year they occurred _____

_____

Family history? *(please circle)* Heart disease Arthritis Cancer Diabetes Other: _____

List any major accidents _____

Medications taken now and 6 months ago?_____

_____

Previous major illnesses & any current illness_____

_____

Previous hospital tests and surgeries (were they successful?)_____

_____

Last GP visit_____ Last X-RAY _____

Do you smoke? YES NO Do you drink? YES NO Take recreational drugs? YES NO

What do you rate your current health out of 10? _____ Why? _____

Do you have any issues relating to: (please circle all that apply)				
Vision	Hearing	Taste	Smell	Dizziness/Vertigo
Breathing	Heart	Digestion	Bowels	Urination
Sexual function	Sensory perception	Recurrent injuries	Motor control (movements)	
Further Notes:				

Consent to Procedures

Chiropractic treatment, including spinal manipulation or adjustment, has been reported to be an effective treatment for spinal pain, some headaches and other similar symptoms. It has endured the test of time. The risk of injuries or complications from Chiropractic treatment is often lower than that associated with many medical and other treatments. The aim of the treatment is always to improve the patient's health, however, a patient should before undergoing a treatment understand the relevant factors in relation to it.

I plan to consult Nicholas Robb or Jessie Chapple with the symptoms mentioned above.

I understand that the following risks may be associated with chiropractic treatment:
1. In a minority of cases the treatment may not be successful and I may be in the same position I am now.
2. Although uncommon the treatment may make my condition worse:
(a) In the case of treatment to the spine and pelvis, temporary soreness occurs in about 1 in 3 patients; strains, sprains and rupture to the muscles, ligaments and other soft tissues occur but are uncommon; rupture to discs between the spinal vertebrae are uncommon but in these cases nerve pain can ensue with radiation of pain into the arms, trunk or legs. In rare instances this can cause permanent disabling pain and weakness in an arm or leg, and in very rare instances bowel, bladder and penis erectile function can be impaired; another rare event is fracture of bone including the ribs.
(b) In the case of manipulation or adjustment to the neck there have been reported additional cases of injury to the carotid and vertebral arteries. These are very rare events (approximately 1:100,000 to 1:400,000) but if they occur they have been known to cause stroke sometimes with serious injury such as quadriplegia or death.
The risk of these most catastrophic events is extremely rare.
3. Some alternatives to the treatment are no treatment, medicine, physiotherapy, osteopathy.
4. This consent is for all treatments for the same symptoms.
5. I will seek explanation for any terms in this consent that I do not understand prior to signing it.
6. I have informed Nicholas Robb or Jessie Chapple of any concerns I have about the effect on my health that I am concerned about in undergoing these procedures.

Patient signature (or legal guardian):- _____ Date: _____

Addendum: I consent to all procedures mentioned above except: _____

Initialled:- Patient: _____ Practitioner:- _____