CHIROPRACTCTOUCH

Date: / /

PATIENT INFORMATION

Name: Middle: Surname: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Occupation: D.O.B: / / Age:

Address: Postcode:

Phone (H): Phone (W): Mobile:

Emergency Contact Name: Emergency Contact Number:

Email: Number of kids:

Concession Card Number: Expiry Date: / / Health Fund:

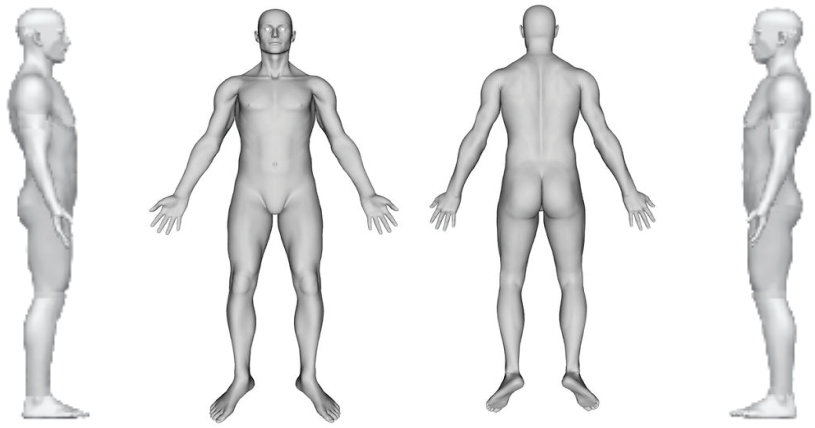
How did you hear about us:

Sports / Hobbies / Activities:

PRESENTING COMPLAINT

What brings you here today?

Please mark on the diagram where you have pain and/or other symptoms:



Are your symptoms affecting any of the following:

- ☐ General Activities
- ☐ Leisure
- ☐ Sleep
- ☐ Work
- ☐ Other (please describe):

Have you had this problem before?

☐ No ☐ Yes

Are your symptoms getting:

☐ Better ☐ Worse ☐ Staying the same

What type of pain are you feeling? ☐ Dull ache ☐ Sharp pain ☐ Tingling ☐ Numbness ☐ Burning ☐ Other (please describe):

When & how did it start?

VAS: On a scale of zero (0) to ten (10), how would you rate your current pain (please circle)?

no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable

What relieves your symptoms?

What makes your symptoms worse?

Do you experience any pain/numbness/tingling/burning travelling down your arms, legs, hands or feet? ☐ No ☐ Yes
If yes, please describe:

Have you received any other forms of treatment for your current condition? ☐ No ☐ Yes
If yes, please describe:

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care before? ☐ Y ☐ N | Date of last adjustment:

If yes, what was your reason for care?

If yes, what was the frequency of care? ☐ weekly ☐ fortnightly ☐ monthly ☐ other:

Have you ever had any form of imaging done of your spine? ☐ Xrays ☐ CT scan ☐ MRI ☐ Ultrasound

MEDICAL & FAMILY INFORMATION

IF UNSURE OR NOT KNOWN, PLEASE LEAVE BLANK

Current Medical Practitioner (GP): Clinic Name:

Hospitalisations and/or surgeries:

Accidents & Trauma:

Fractures:

Family History:

☐ Cancer ☐ Stroke ☐ Mental Illness
☐ Diabetes ☐ Heart Attack ☐ Seizures / Convulsions
☐ Arthritis ☐ High Blood Pressure

Current Medicatios &/or Supplements

Do you smoke? ☐ No ☐ Yes If yes, how many a day?

How many glasses of water do you drink per day?

Do you drink alcahol?
If yes, how much? ☐ No ☐ Yes

How old is your Pillow: Matress:

Do you wear orthotics? ☐ No ☐ Yes If yes, how old are they?

OTHER CONCERNS

Do you suffer or have you ever suffered from any of the following?

☐ Neck Pain/stiffness
☐ Mid/Upper Back Pain
☐ Low Back Pain
☐ Numbness/Tingling
☐ Headaches/Migrains
☐ Dizziness/Vertigo
☐ Ringing in the ears
☐ Earaches
☐ Shoulder Problems
☐ Elbow Problems
☐ Wrist Problems
☐ Hip Problems
☐ Knee Problems
☐ Ankle Problems
☐ Foot Problems
☐ Digestive Problems
☐ Stomach Problems
☐ Menstrual Problems
☐ Bladder Problems
☐ Liver/kidney Problems
☐ Heart Problems
☐ Lung Problems
☐ Chest Pain
☐ Tiredness/Fatigue
☐ Nervousness/Anxiety
☐ Depression
☐ Moodiness
☐ High/Low Blood Pressure
☐ Difficulty Sleeping
☐ Weight Problems
☐ Asthma

DESIRED OUTCOMES

What do you hope to achieve from your care (please tick)?

☐ Check up (spinal assessment)
☐ Initial Care (Symptomatic/Crisis care)
☐ Corrective Care (Rehabilitation & Stabilisation)
☐ Wellenss Care (Maintenance & Prevenation)

CONSENT TO CHIROPRACTIC CARE

Chiropractic is recognized as being an effective and safe method of care for many conditions. However you must recognize that there are risks associated with all health care procedures, which you should be informed of.

If you have any questions related to the treatment you are about to receive, please speak to the Chiropractor.
Please read the following carefully:

1. I acknowledge that I have discussed with Dr Ilias Varlokostas/Dr Jessica Mah (or other qualified chiropractor) the rare risks associated with my proposed treatment which include, but are not limited to:

   - Muscle or joint soreness/strains
   - Headaches, nausea and dizziness
   - Fractures (usually rib fractures - generally only occur when bone softening disease is present)
   - An exacerbation of the underlying condition

   In extremely rare circumstances the following may occur:

   - Stroke or stroke like symptoms - approx 1 / 5.85 million (neck manipulation)
     Haldeman, et al. Spine vol 24-8 1999

   - Strain/injury to a ligament or disc - <1 / 139,000 in the neck or <1 / 62,000 in the low back
     Dvorak study in Principles & Practice of Chiropractic, Haldeman. 2nd Ed

2. I acknowledge that I have the opportunity to ask questions about the nature, extent and purpose of the care to be provided and have been given sufficient time to make a decision.

3. I acknowledge that I am aware of and understand the potential risks. I appreciate that like all health care modalities, results are not guaranteed. I understand that symptoms may even deteriorate despite treatment as some cases may not respond favourably to treatment as they are unpredictable and may occur at no fault to the Chiropractor due to a considerable degree of variation in individual patient response.

4. I do not expect the Chiropractor to be able to anticipate all potential risks and complications associated with the proposed care.

5. I hereby consent to and request chiropractic care. Consent includes physical examination, chiropractic spinal and extremity joint manipulation, and or other chiropractic procedures including modes of physical therapy.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

From time to time, we may use and disclose your medical information to other health professionals, such as medical doctors, specialist doctors, surgeons, radiologists, podiatrists etc. I understand that the specific purpose of this authorization is for furthering my health care.

I voluntarily authorize for the chiropractors at Chiropractic Touch to disclose any and all medical or personal information determined necessary, at their discretion.

I understand that permission to use or disclose my medical or personal information may be revoked, in writing, at any time.

Please note: At no time will medical or personal information be used for marketing or advertising purposes.

CLINIC POLICY

As a courtesy to this practice, we would appreciate payment at the time of consultation. SMS appointment reminders will be sent, if you are unable to keep an appointment, prior notice is required. Failure to give sufficient notice may incur a missed appointment fee. Any patient receiving treatment whereby payment is to be made by a third party (eg motor accident claim, workcover) will be personally liable for payment in the event of non-acceptance of the claim.

I hereby agree to pay all costs associated with the recovery of any outstanding accounts should the account fall overdue and be passed to the debt collection agency.

I have read and understood all the above information and give my consent to commence chiropractic care. I understand that I can withdraw my consent at any time.

Your Signature: _____
(Parent or Guardian signature if patient under 18yrs of age)

Print Name: _____

Date: / /

Chiropractor Signature: _____

Chiropractor Name: ☐ DR ILIAS VARLOKOSTAS
☐ DR JESSICA MAH
☐ DR JOSHUA CHIN

Date: / /