BAY CHIROPRACTIC

CONFIDENTIAL PATIENT HISTORY FORM

Title:		First name:			Surname:						
Address:											
Suburb:				State:			Postcode:				
Phone:	(H):		(W):			(M):					
Email Address:											
Date of Birth:	/ /	Occupation:				Number of children:					
Have you been to a chiropractor before?	**Yes / No**	When was your last treatment?									
Private Health Fund Name?		Who referred you to this clinic?									
Will this treatment involve worker's compensation or third party insurance?	**Yes / No**										

In your own words please explain your main reason for attending this chiropractic clinic?

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How long have you had this complaint?	

Have you had any treatment for this complaint prior to this consultation? Please provide details:

.....

.....

Please circle any of the areas below that are or have involved any problems:

Headaches / Migraines
Dizziness / Loss of Balance
Visual changes
Hearing / Ear problems
Sinus / Asthma / Respiratory problems
Reflux
Decreased sense of taste or smell
New or recurrent cough
Heart / Cardiac condition
Constipation / Diarrhoea
Anxiety / Stress / Depression
Unexplained weight loss or gain
Sexual or genital problems
Hormonal / Endocrine condition
Pain with urination or bowel motion
Blood disorder / condition
Arthritis
Allergies
Pins & needles or numbness in hands/feet
Loss of consciousness

Please turn over

Do you suffer from a particular illness / condition? Please list: ....
Have you ever been to hospital or had any surgery? Please give details: .....
Have you fractured, broken or dislocated any part of your body? Please give details: .....
Have you had a car, bike or other serious accident? Please give details and treatment received: .....
Have you had an X-ray, CT scan, Ultrasound, MRI or other scan? Please give details: .....
Are you taking any medication? Please list: ....
Have you taken long term medication in the past? Please list: ....

Do you?	(i) smoke: **Yes / No**	(ii) have a history of smoking: **Yes / No**	(iii) drink alcohol: **Yes / No**

PATIENT INFORMATION PRIOR TO TREATMENT

Changes to the law now require all practitioners who manipulate the spine to warn patients of the material risks. In extreme rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulation) 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 low back (1 in 62,000).

Chiropractic adjustments (manipulation) 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).

If you have any questions relating to the treatment you are about to receive, please speak to the chiropractor. If you understand the above information and give your consent to treatment please sign below.

Patient Signature: ..... **Date:** / /
(parent/guardian if under 16 years old):