ROF date: Entered Capable:

EMERGENCY
CHIROPRACTOR MELBOURNE

REASON FOR YOUR VISIT TODAY? *CONFIDENTIAL

☐ Chiropractic Initial Assessment ☐ Myotherapy & Massage Initial Consultation ☐ Weight Loss Consultation
☐ Pillow, Sleep & Mattress Assessment ☐ Foot Orthotic Posture Scan ☐ Other: _____

PERSONAL DETAILS:

Full Name:					
Address:		**Suburb, Postcode**			
Phone (home):		**Phone (mobile):**			
Email:					
D.O.B.:	**Age:**	**Occupation:**			
Partner's name:		**Partner phone no:**		**Kids?**	
GP name:		**Clinic & Location:**			
Health Fund:		**Chiropractic cover?**			
Consent to contact your partner or GP in case of an emergency? (please circle): YES NO					
How did you find us? (please circle)	**Walking/Driving past Yellow pages Google Flyer Website Newsletter Referral Who can we thank for referring you?**				
Previous chiropractor	**Yes**	**No**	**Who? When?**		
Complaint?			**Did it help?**		
Have you had spinal X-Rays?	**YES**	**NO**	**If yes, when?**		

MEDICAL & GENERAL HEALTH HISTORY:

Are you PREGNANT?		**If yes, how many weeks?**			
List current MEDICATIONS					
Any family/personal history of serious or hereditary diseases?					
Please list SURGERIES (incl. yr)					
Avg length of SLEEP / night?		**Age of MATTRESS?**		**Age of PILLOW?**	

STRESSES

Physical (falls, accidents, work posture) =
Bio-chemical (smoke, diet, drugs/alcohol) =
Psychological, Emotional (work, financial, relationship stresses) =

GENERAL SYSTEM REVIEW

(Tick Left Box = Past symptoms, Right Box = Current symptoms)

☐ ☐ Pins & Needles, Numbness, Weakness
☐ ☐ Soreness in Neck
☐ ☐ Dizziness/Light-headed/Vision problems
☐ ☐ Headaches
☐ ☐ Painful/Clicking jaw
☐ ☐ Shoulder Pain/Stiffness/Tension
☐ ☐ Mid Back Pain/Tension
☐ ☐ Pain in Ribs or Chest
☐ ☐ Low Back Pain/Weakness/Stiffness
☐ ☐ Hip Pain/Stiffness, Buttock & Leg Pain
☐ ☐ Pain on Straining/Coughing/Sneezing
☐ ☐ Diabetes, kidney disease or heart disease
☐ ☐ Knee/Foot/Ankle trouble
☐ ☐ Unexplained weight loss
☐ ☐ Leg/Muscle Cramps
☐ ☐ Arm/Elbow/Wrist/Hand Pain
☐ ☐ Stroke (TIA)
☐ ☐ Loss of Smell/Taste
☐ ☐ Allergies, Colds and Flu
☐ ☐ Fatigue
☐ ☐ Loss of Grip
☐ ☐ High/Low Blood Pressure
☐ ☐ Smoker (___/day)
☐ ☐ Asthma/Coughing
☐ ☐ Ear Disorders
☐ ☐ Freq Loose Stools
☐ ☐ Cancer
☐ ☐ Nausea/Vomiting
☐ ☐ Menstrual Issues
☐ ☐ Diarrhoea/Digestion
☐ ☐ Constipation
☐ ☐ Abdominal Pain
☐ ☐ Drink Alcohol (__/wk)
☐ ☐ Medical devices and implanted devices such as intra-cranial aneurysm clips, cardiac pacemarker, coronary stenets, intra ocular foreign bodies and cochlear implants (circle relevant)

REASON FOR YOUR VISIT TO THE CHIROPRACTOR:

List COMPLAINTS	When did this BEGIN?	SEVERITY Mild=1 Severe=10	HOW did this begin?	Have you had this BEFORE?	What makes this complaint WORSE?	What other TREATMENT have you had for this?
1.						
2.						
3.						
4.						

If you have no symptoms or complaints and are here for chiropractic wellness services, please write "WELLNESS CHECK UP"

CONSENT FORM

We are firmly committed to safety and efficacy at our practice. Spinal manipulation is a complex clinical skill and will only be performed by a suitably qualified professional or intern under clinical supervision. We endeavour, through professional conferences, journals and continuing education to maintain the highest standards of care. In any clinical or medical procedure that deals with people there are inherent risks. Complications of spinal manipulation when performed correctly and appropriately are extremely low in comparison to any other form of treatment. There is a possibility (figures suggest one chance in two million) that spinal manipulation of the cervical spine (neck) may be associated with damage (major or minor) to the blood supply of the brain (stroke). As an indication of comparative risk there is an accepted figure of sudden death under general anaesthesia of one in ten thousand; death caused by prescription anti-inflammatory drugs is 3,300 times more likely than spinal manipulation. Other risks associated with spinal manipulation may relate more specifically to your condition or aggravation to the spinal structures themselves such as the bones and ribs (a possibility of fracture) or the discs, ligaments or nerves. The purpose of our physical examination is to assess your condition with these things in mind so that we may choose the most appropriate technique for you. We believe that our expertise and experience enable us to provide the safest possible care. However, we would ask your co-operation in keeping us fully informed of your symptoms, past illnesses and any changes in your medical history including medications. If you have any queries or concerns please feel free to discuss these with us at any time. I have read and understood the above, and that I may choose to have no treatment or alternate treatment for my condition. I hereby consent to chiropractic treatment at our practice. I understand that I may withdraw my consent at any stage. I have had the opportunity to discuss this consent form and proposed treatment with the chiropractor. Furthermore, x-rays may be taken to better assess your condition. The proposed diagnostic imaging procedure has been explained to me in full and I have had the opportunity to ask questions. OUR PRIVACY COMMITMENT: All information provided to our chiropractors and support team is confidential and will only be used by and available to your practitioner. As part of our commitment to your wellbeing, we consider it important to keep your General Practitioner informed of your care and treatment at this clinic. We may therefore send an explanatory note or report to your GP.

Signature…… Date...../2016

Name (please print) …… Doctor's Signature:.....

****50% missed fee will apply if 6hrs notice is not provided prior to appointments****

OFFICE USE

ACT MAN	AO DP

P:

S: