

CHIROPRACTIC NEW PATIENT FORM

PERSONAL INFORMATION

Mr Mrs Ms Miss Master Other

First Name: Surname Date:/...../.....

Address: Suburb Postcode DOB:/...../.....

Phone no: Home: Work: Mobile:

E-mail@..... Partner/Spouse: No. of Children:

Occupation: Who recommended you to this centre?

Medical Doctors Name Medical Centre Name

Are you responsible for this account? Yes WorkCover TAC Veterans

Do you have private health coverage? Yes/No If yes, which fund

ABOUT YOUR HEALTH

1. Why are you here?

2. Have you had any chiropractic care before? If so, please answer the following:

My previous experience of chiropractic was:	Poor	Average	Excellent
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3. Have you ever been diagnosed as having any of the following?

	Y	N		Y	N		Y	N
Fractures			High/Low Blood Pressure			Metal implants/plates/screws		
Hospitalization			High/Low Blood Glucose			Lung conditions e.g asthma		
Surgery			Heart problems			Blood disorders		
Incontinence			Epilepsy			Rheumatoid arthritis		
Regular headaches/migraines			Osteoporosis			Thyroid dysfunction		
Allergies/food intolerances			Unexplained weight loss			Stroke		
Diabetes			Cancer			Anaemia		
Neurological conditions			Kidney disease			Multiple Sclerosis		

4. Now or in the past have you ever experienced any of the following:

	Y	N		Y	N		Y	N
Dizziness/light-headedness			Being knocked unconscious			Pins and needles or numbness		
Fainting or blackouts			Pain waking you at night			Pain on coughing/sneezing		

5. What are three things you can't do because of your pain in the last week?

1. 2. 3.

6. What are three health goals you would like to achieve, and in how long?

1. 2. 3.

7. List your current medication below

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MEASURING YOUR PAIN LEVELS:

Please circle your **current** pain level on the following scale:

No Pain										Unbearable Pain
1	2	3	4	5	6	7	8	9	10	

Please circle your **worst** pain level in the last week on the following scale:

No Pain										Unbearable Pain
1	2	3	4	5	6	7	8	9	10	

MEASURING YOUR WELL-BEING LEVELS:

Chiropractic can sometimes help with more conditions beyond back & neck pain. Please rate the following with respect to frequency over the last week by circling never, rarely, occasionally, regularly or constantly.

	Never	Rarely	Occasionally	Regularly	Constantly
How often do you have neck pain?	0	1	2	3	4
How often do you have headaches?	0	1	2	3	4
How often do you feel dizzy or light-headed?	0	1	2	3	4
How often do you have back pain?	0	1	2	3	4
How often do you have shoulder/elbow/wrist/hand pain? (please circle)	0	1	2	3	4
How often do you have hip/knee/ankle/foot pain? (please circle)	0	1	2	3	4
How many times do you exercise per week?	4	3	1	0	0
How often do you feel fatigued or have low energy levels?	0	1	2	3	4
How often do you experience depression or lack of interest?	0	1	2	3	4
How often do you have difficulty falling asleep or staying asleep?	0	1	2	3	4

Score: /40

INFORMED CONSENT

Chiropractic care is very safe and effective health choice. However with any form of healthcare no one can guarantee results and there are potential risks and rare complications that you should be informed about. These include (although not limited to) muscle and joint soreness, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of the underlying condition. Often these potential risks and complications cannot be predicted. The most serious potential injury is that of a stroke and its risk is estimated to be one incident in every 5.4 million. chiropractic adjustments. Your answers to this confidential questionnaire will help ensure any risks are minimized. We rely on the accuracy and completeness of what you tell us. At all times your comfort and peace of mind is important so please tell us if you have any concerns. We comply with the Privacy Act and we do not share your information with other people without your prior permission.

CANCELLATION POLICY

The clinic is a very busy clinic. Often we have to place patients on a waiting list as they cannot have their first preference appointment. If a patient cancels an appointment, without a reasonable explanation and within 24 hours of their appointment, the centre will bill a Cancellation Fee of \$25.

DO NOT SIGN the following until you have spoken with your Chiropractor:

I understand the above, have been given the opportunity to ask questions and have been satisfied with the answers. Having discussed and understood the Chiropractors recommendations, I grant permission for care to proceed.

I understand I can withdraw this permission at any time.

Patient's signature:..... Date...../...../.....

(Parent or Guardian if patient under 18)

Patients Name (Please print)Chiropractor.....

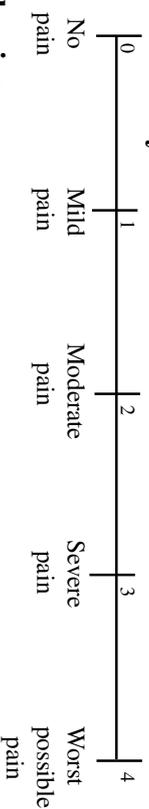
Functional Rating Index

For use with Neck and/or Back Problems only.

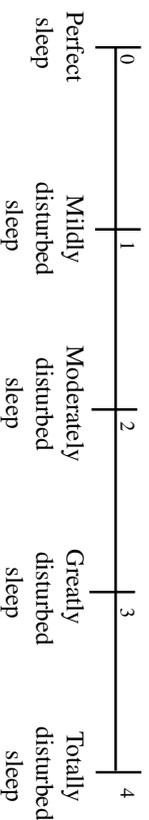
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

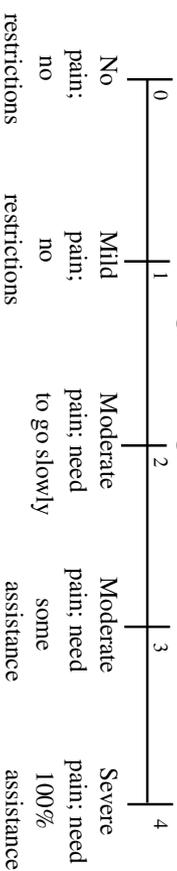
1. Pain Intensity



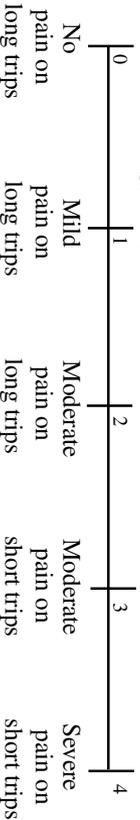
2. Sleeping



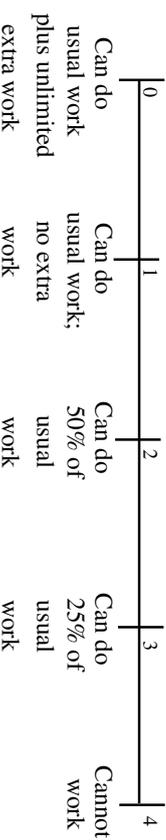
3. Personal Care (washing, dressing, etc.)



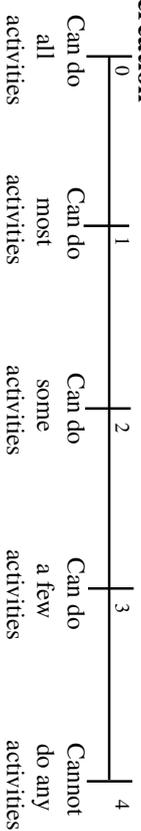
4. Travel (driving, etc.)



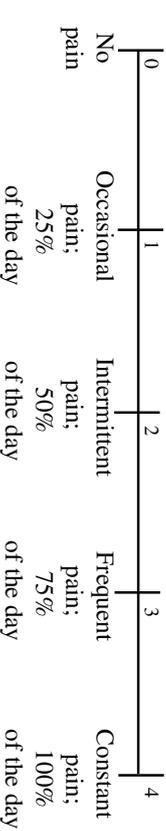
5. Work



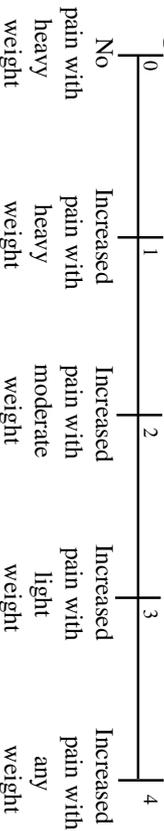
6. Recreation



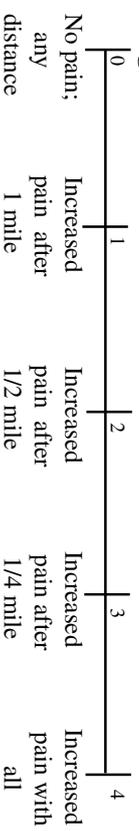
7. Frequency of pain



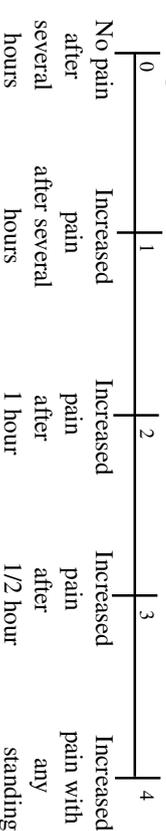
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Date _____

Total Score _____