MOSMAN CHIROPRACTIC CENTRE

PATIENT DETAILS

Date: _____

Name: (Mr, Mrs, Miss, Ms) Please circle _____

Address: _____ (Post Code) _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Date of Birth: / / **Age:** _____ **Marital Status:** S / M / D / W **No. Children:** _____

Occupation: _____ **Email:** _____

Health Insurance: _____ **Chiropractic Cover:** ☐yes ☐no

Previous Chiropractic Care? ☐Yes ☐No **whom:** _____ **when:** _____

Doctors Name: _____

Who recommended you to this clinic? _____

Please describe in your own words, your present complaint(s): _____

_____

_____

On a scale of 0 – 10 in which box would put your current pain level:
Indicate range of pain level from minimum to maximum if necessary.

0	1	2	3	4	5	6	7	8	9	10
No pain										Maximum pain

Please tick any of the following conditions you have had in the past or present:

- ❑ Headaches
- ❑ Arthritis
- ❑ Heart / Blood Pressure Problems
- ❑ Respiratory Problems
- ❑ Menstrual / Menopausal
- ❑ Gastrointestinal Problems
- ❑ Urinary Problems
- ❑ Poor posture/scoliosis
- ❑ Stress / Emotional problems
- ❑ Cancer
- ❑ Serious Infectious Disease
- ❑ Accident
- ❑ Bone Fractures
- ❑ Eye problems
- ❑ Diabetes
- ❑ Frequent colds/flu
- ❑ Allergies / Sinus Problems
- ❑ Dizziness / Fainting

Have you ever had surgery for any of the above conditions: ☐Yes ☐No

If Yes, please give details: _____

Medication currently taking: _____

List X rays taken: _____

Tick ONE box which reflects best how we can help:

- ❑ I have a problem and only want help for this.
- ❑ I have a problem for which I want help, including how to prevent in the future.
- ❑ I have a problem for which I want help and I am interested in improving my health.

Signature: _____

(If under 16 years parent /guardian must sign): _____

NEW PATIENT CONSENT FORM
FOR CHIROPRACTIC CARE

Chiropractic care 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, including assessment and treatment, which you should be informed about.

Please read the following carefully:-

1. I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, stroke (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I have had the opportunity to discuss the proposed care with my chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

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

5. I hereby acknowledge my consent to the performance of the chiropractic care. I understand that I can withdraw consent at any time.

6. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms. (**current statistics** eg between 1 in 2 million to 1 in 5.85 million- Haldeman,et al.Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (**current statistics** eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.) For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

We assure you your safety & well being are our utmost concern. Please feel free to discuss any change in your condition or any concern you have at any time.

.....
Patient's Signature or Guardian if patient is under 18yrs.

Dated: .....
Chiropractor's Signature