BAY CHIROPRACTIC

CONFIDENTIAL PATIENT HISTORY FORM

Title:		First name:			Surname:				
Address:									
Suburb:				State:			Postcode:		
Phone:	(M):		(W):			(H):			
Email Address:									
Date of Birth:	/ /	Occupation:				Number of children:			
Who recommended you to our Practice?									
Private Health Fund Name?				Member Number?					
Who is your General Practitioner?									
What do you do for exercise?									
Have you been to a chiropractor before?	**Yes / No**			When was your last treatment?					

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

.....

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 currently taking any medication or 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**

INFORMED CONSENT PRIOR TO TREATMENT

I consent to the collection of my health information _____ Date: / /

The World Health Organization regards manual mobilization and/or spinal manipulative treatment conducted by chiropractors to be a safe and effective treatment with few, mild, transient AEs (WHO. Guidelines on basic training and safety in chiropractic. Switzerland: World Health Organization; 2005.) Recent studies support the evidence of spontaneous causality or minimally suggest a very low risk for serious adverse events following spinal manipulative therapy (Tuchin P. A replication of the study 'Adverse effects of spinal manipulation: a systematic review'. Chiropr Man Ther. 2012) 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). 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).

I understand that discomfort may occur following treatment. This may include an exacerbation of symptoms, strains, sprains or general soreness. It is my responsibility to notify the practitioner should any changes occur in my health status. Including medications, injury or a new diagnosis.

TO BE SIGNED WITH PRACTITIONER

If you have any questions relating to the explained treatment, 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):