



New Patient Intake Form:

**PATIENT DETAILS**

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Duties \_\_\_\_\_

Marital Status \_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

**HEALTH HISTORY**

Have you seen a Chiropractor before \_\_\_\_\_ When was your last visit \_\_\_\_\_

Reason for seeking care \_\_\_\_\_

Describe any health problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any previous injuries, surgeries, accidents \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications \_\_\_\_\_

What aggravates your condition/pain \_\_\_\_\_

What relieves your condition/pain \_\_\_\_\_

Worse at certain times of day Y / N If yes, when \_\_\_\_\_

Is the condition pain interfering with daily activities \_\_\_\_\_

How committed are you to resolving your health concerns 1 2 3 4 5 6 7 8 9 10 (please circle)

Condition	Often	Sometimes	Never	<p style="text-align: center;"><b>Circle Your Pain</b></p> <p style="text-align: center;"><b>PAIN BODY DIAGRAM</b></p>
Headaches				
Migraine				
Neck pain				
Mid back pain				
Lower back pain				
Hip pain				
Shoulder pain				
Nerve pain				
Foot pain				
Knee pain				
Jaw issues				
Hormonal issues				
Digestion issues				
Allergies				
Other:				

**Consent:**

Chiropractors who use adjustments (manipulation) are now required to advise patients with spinal problems of the following:

Over the years there have been rare incidents of injury to the vertebral artery during a neck adjustment. This may cause stroke or stroke like symptoms, which are usually temporary in nature. The chances of this happening are 1 in 1.5 million. Prior screening during your consultation minimises this risk.

Other slight risks with treatment include muscle strain and disc injuries. With these incidents a full recovery is anticipated.

Further diagnostic test such as x-ray, EMG may be performed to further minimise any risk.

Chiropractic is considered safe and effective for of treatment for your musculoskeletal problems. No person in Australia has died following chiropractic adjustment. If you have any queries of concerns please discuss further with your chiropractor.

I understand the risks associated with chiropractic treatment and consent to the treatment advised by the chiropractor, which may include spinal manipulation, dry needling and/or soft tissue therapies. I understand I can withdraw my consent at any time.

**Cancellation Policy.**

It is our aim to always provide high quality and timely treatment. To assist in this matter, if you are unable to attend your appointment please notify the clinic 24 hours prior to your appointment. A cancelled or missed appointment may incur a 50% cancellation fee, if the appointment fails to be rescheduled.

I understand the clinic functions on a payment on the day basis and I am financially obligated for any fees, including all outstanding amounts after MVA, Workers Compensation, Medicare and other insurance claims have been finalised.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_