Confidential Patient History

Name:_____

Address:_____

Date of Birth:_____Occupation:_____

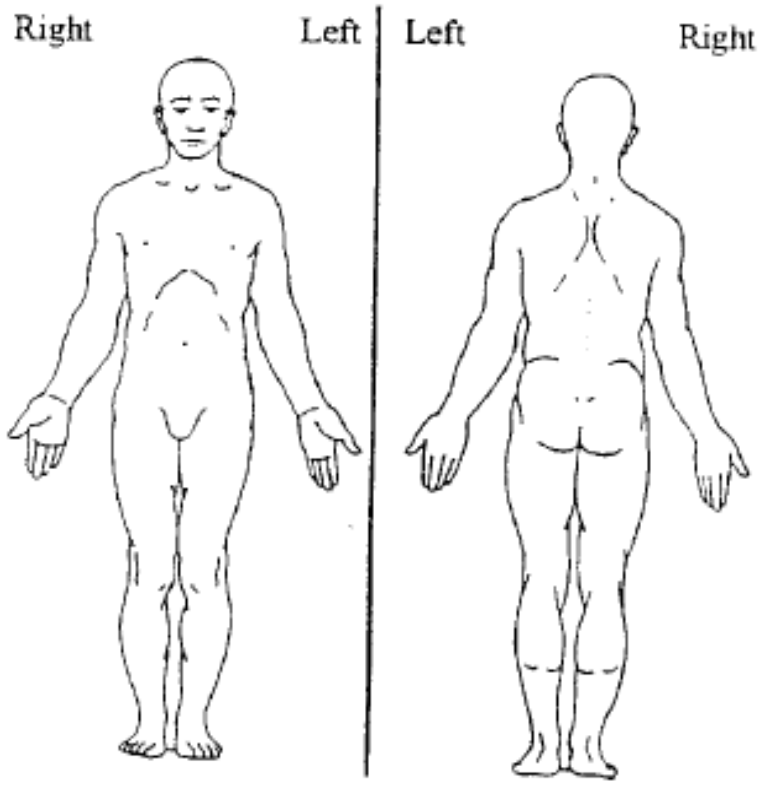
Phone:(H)_____(W)_____

Email:_____

Are you claiming workers compensation or 3rd Party for the present complaint? Yes ☐ No ☐

Please draw where you feel the sensations using the appropriate symbols

Aching: ooooo	Burning:XXXX	Stabbing:\\\\\\ other:~~~
Numbness:====	Pins & Needles:VVVV	Throbbing: +++++



Please put a mark on the line to indicate how bad your pain is today

No Pain — Worst Possible Pain

If you have consulted anyone about your current condition who was it, what was their diagnosis and what treatment was given_____

_____

_____

*Please turn over page

Does this pain/symptom wake you up at night? ☐ Yes ☐ No
Have you experienced a fever (felt unusually hot) with this complaint? ☐ Yes ☐ No

When did these symptoms start?_____
What caused your Symptoms? (ie A fall)_____
What makes your symptoms worse?_____
What makes your symptoms better?_____
What does your symptoms prevent you doing?_____

Since your symptoms started this time have they been?

☐ Getting progressively Worse ☐ Getting better
☐ Staying about the same ☐ Seem to get better than worse

Please list the medication/pills you are taking?_____
_____
Please list any operations you have had?_____
_____

Have you had any X-rays, CT scans or MRI Scans? ☐ Yes ☐ No if yes, What were they for?_____
_____
List any broken bones or dislocations you have had_____
_____
If you had any injuries from motor vehicle accidents please list them_____
_____

Do you ever experience headaches? ☐ Yes ☐ No

Have you recently experienced any;
Fainting ☐ Yes ☐ No
Dizziness or Light-headedness ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Numbness ☐ Yes ☐ No

Have you had any recent changes in vision or blurriness in sight?..... ☐ Yes ☐ No

Do you have or have you ever had high blood pressure?..... ☐ Yes ☐ No
Do you smoke?..... ☐ Yes ☐ No
Have you ever had a stroke or blood clot?..... ☐ Yes ☐ No
Have you ever had cancer or a tumour?..... ☐ Yes ☐ No
Have you ever been diagnosed with Osteoporosis (weak bones)?..... ☐ Yes ☐ No

Have you had any unexplained weight loss lately?..... ☐ Yes ☐ No
Do you experience pain or have difficulty on urinating?..... ☐ Yes ☐ No
Have you noticed any blood on going to the toilet?..... ☐ Yes ☐ No
Do you experience stomach pains?..... ☐ Yes ☐ No
Have you any skin rashes?..... ☐ Yes ☐ No
Do you have any heel pain?..... ☐ Yes ☐ No

Do you have any other medical condition? Please describe_____
_____
_____
_____

CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise 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 Matthew Q Smith 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, strokes (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 explained to me any terms in this consent that I do not understand. These terms were……[Insert Details]

3. I have had the opportunity to discuss the proposed care with [insert name of practitioner]. 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.

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

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

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by [insert name of practitioner] and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

7. 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."

Patient's Signature …… Dated:…….
(Parent/Guardian to also sign if patient is under 18)

Patient's Name (printed) ……

Chiropractor's Signature ……Dated:……

MULLUMBIMBY CHIROPRACTIC AND HEALTH CENTRE AGREEMENT

• If it is necessary to cancel or re-schedule your appointment we require that you call by 11 a.m. one working day in advance. Please do not SMS or email to cancel or re-schedule appointments.

• Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely chiropractic care. Failure to do so will result in a $20 fee.

• If you fail to attend your scheduled appointment, you will be also charged a $20 cancellation fee. Further no shows may attract a full fee.

• Whilst we attempt to send reminder SMS notifications about your appointment, this should not be relied upon and it remains your responsibility to remember and uphold your appointment. You do not need to respond to this message unless you are unable to make your appointment.

• If you experience an adverse reaction, please call the clinic. If you need to cancel an appointment please advise of the reason for this.

• I have read and understand the above housekeeping rules for Mullumbimby Chiropractic and Health Centre.

• I Authorise for all practitioners of Mullumbimby Integral Health to obtain information from and release information to my Nominated Treating Doctor and other nominated treating allied health professionals including medical imaging relevant to my condition so that the highest level of care may be provided. I understand that the request for this information is conditional on the information being used solely for the purpose of managing my rehabilitation or treatment. All information obtained will be treated in a confidential manner.

Patient's Signature…..……

Chiropractor: Matthew Q Smith

Chiropractor's Signature: ……Date ……..