AV Chiro

Confidential New Patient Questionnaire

Personal Details

Title: Mr Mrs Ms Dr Mast Miss Name: _____ Date: _____

Address: _____

Suburb/Town: _____ Postcode: _____

DOB: _____ Email: _____

Home Ph: _____ Mobile: _____ Work Ph: _____

Occupation & Employer: _____

Emergency Contact: _____ Phone: _____

AV Chiro recognises the importance of protecting your privacy and abides by the Australian Privacy Principles contained in the (amended version: 2014) Privacy Act 1988. The information that you give us will only be used to contact you regarding your health needs and dealings with us.

I would like an appointment reminder: SMS ☐ Email ☐ No thanks ☐

I am aware of the attached privacy statement. Signed: _____

Do you have a: Student / Pensioner card? DVA file number? _____

CDM / Medicare Referral? Workcover claim number? _____

How did you hear about our clinic?

Friend/Family member Name: _____

Other Health Professional/Chiropractor Name: _____

Internet Google Social Media

AV Website Other

Private Health Insurance _____

Promotion / Voucher

Walked Past

Other _____

Chiropractic History

Have you ever had Chiropractic care before? Yes No

If so, when was your last visit? _____

Name of Chiropractor and Clinic: _____

Were x-rays taken? Yes No

How would you rate your results? Excellent Good Poor

Please continue over page

Current Major Complaint

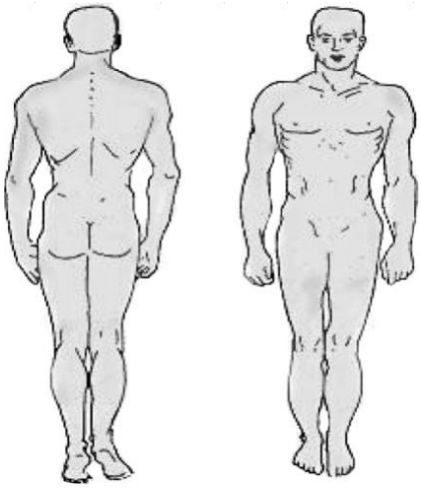
Describe your current condition: _____

_____

Please indicate the area/s of discomfort on the diagram (on right):

Please indicate the severity of discomfort you are experiencing right now:

1	2	3	4	5	6	7	8	9	10
No pain		Discomfort			Very sore		Extreme pain		



Does your condition interfere with:

Work ☐ Sleep ☐ Exercise ☐ Routine ☐

When did your symptoms start? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Are they getting worse? Yes No Has this occured before? Yes No

If so, when did it occur? _____ How often? _____

Do you know what caused it? _____

Have you received any treatment for this condition? If so, please list: _____

_____ Was it effective? Yes No

General Health

A poorly functioning spine and nervous system can affect the way your entire body functions. Are you experiencing any other health conditions, such as:

Please cross and write 'O' for occasionally or 'F' for frequently.

Headaches/Migraines ☐	Asthma/Problems breathing ☐	Muscle weakness ☐
Double/Blurred vision ☐	Cold/Painful extremities ☐	Fever/Nausea ☐
Indigestion/Heartburn ☐	Dizziness/Loss of balance ☐	Painful cough/sneeze ☐
Tingling/Numbness ☐	Constipation/Diarrhoea ☐	Ringing in ears ☐

Please list any other health concerns: _____

Are you taking any medication? If so, please list: _____

What lifestyle activities have you had to give up due to your current health condition? _____

_____

What are your health and lifestyle goals for the future?

3 months: _____

On going: _____

Thank you for taking the time to complete this form.

AV Chiro

Informed Consent to Chiropractic Care

Chiropractic Adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives [A Risk Assessment of Cervical Manipulation, JMPT, 1995 & The Manga Report, Ontario Ministry of Health, 1993].

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approximately 1 in 2.15 million). Other very slight risks include, but are not limited to, strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) [Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed].

Chiropractic Adjustments are a low force input into a specific joint aimed at treating subluxations. They are tailored to suit each patient and babies/children will have a modified treatment that is of even lower force. Our Chiropractors will also often use the Activator tool which will be demonstrated before the adjustment.

If you have any questions related to the treatment that you or your child are about to receive, please speak to your Chiropractor.

Please do not sign until you have spoken to your Chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the Chiropractor and give my consent to treatment. I understand that results are not guaranteed and that the Chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.

I have had the opportunity to ask questions about the nature, extent, and purpose of the proposed Chiropractic care and I have been given sufficient time to make a decision giving consent for the care to proceed.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition/s for which I seek treatment by Dr Andrew Vincent *B.App.SC (Chiropractic)*, Dr Mark Whitfield *B.Sc, M Chiropractic*, and/or anyone working in this clinic authorised by Dr Andrew Vincent *B.App. Sc (Chiropractic)*. I understand I can withdraw my consent at any time.

Patient's Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature: _____
(if patient is under 18)

If Female, could you be pregnant? Yes No

Chiropractor's Signature: _____

Thank you for taking the time to complete this form.