

Patient information form (please PRINT)

Name: _____ D.O.B. _____

Address _____ Suburb _____ postcode _____

Phone numbers: home _____ work _____ mobile _____

Email _____ Occupation _____ Employer _____

Regular Medical Doctor or Clinic _____

Emergency Contact: _____ Number _____ Relationship to you _____

Partner/ Spouse: _____ no of Children ____ Do they attend this clinic? Y/N

Who is responsible for your account? Yourself/Workcover/Comcare/TAC/Veterans Affairs (circle)

Do you hold a Concession Card? Y/N _____ Type _____

Private Health Insurance Y/N _____

What is the reason/s that you have come to this Clinic?

Do you have any other health concerns? _____

Sport/exercise and how often? _____

How did you find out about Better Backs? _____

Any medications (include contraceptive medications) _____

Any vitamin or herbal Supplements? _____

Coffee(cups per day) _____ Tea (cups per day) _____ Water (glasses per day) _____

Cigarettes (per day) _____ Alcohol (how often and how much?) _____

Have you ever seen a chiropractor before? YES/NO (circle) if yes who, when and what for?

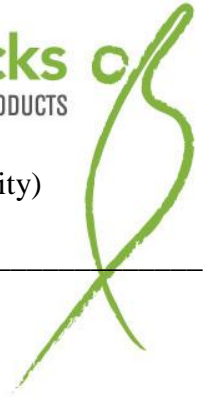
Have you or a family member ever been diagnosed with the following?

Cancer Y/N Stroke Y/N Rheumatoid Arthritis(or other similar) Y/N Diabetes Y/N

Osteoporosis Y/N Heart attack or other heart conditions Y/N Blood disorders Y/N

Mental health disorders Y/N Other (specify) _____

PTO ->



Significant trauma, car accident/s or broken bones Y/N Specify if yes (when and severity)

Have you ever been hospitalized or had any surgery? Y/N specify if yes

In the last 12 months have you had the Flu or any other infection/s?

It is important to your care that you answer the above questions honestly and to the best of your knowledge.

Your Health Goals are(circle appropriate response/s):

Have less pain Y/N/NA To have better function Y/N/NA Maintain Changes Y/N/NA Better Vitality Y/N
Palliative care Y/N/NA Less recurrent illness/infections Y/N/NA Improve fertility/Reproductive health Y/N/NA
Sporting performance enhancement Y/N/NA Lose Weight Y/N/NA Other Y/N(please write below)

INFORMED CONSENT FOR CHIROPRACTIC EVALUATION AND CARE.

I understand that for the chiropractor to be able to make a decision on the cause of my condition, a physical examination and history will be conducted of which I agree to.

Name: _____ Signature: _____ date: _____

I _____ have consulted Dr David Jones and have been advised that the following treatment/s is best suited to my condition. _____

As all health care practices carry a degree of risk; The risks associated with chiropractic include the following, but are not limited to, post treatment soreness, bruising, joint sprains, fractures, disc injuries, strokes and stroke like episodes. The risk of stroke or stroke like symptoms following a neck manipulation is between 1 in 3.8 million manipulations¹ and 1 in 5.8 million manipulations². Every effort to minimize the risk of above side effects is made at this clinic, including the taking of a history and performing procedures. It is important that you reasonably answer all questions. If you have any further questions about you treatment, please ask the chiropractor you are consulting.

I have read the above and understand or have had any terms unfamiliar to me explained and I understand the risks associated with my treatment.

I also wish this consent to cover any future adapt ions to my treatment or treatment for any future conditions, on the provider I have given verbal consent. I also understand that I can withdraw my consent for treatment at any time.

Please note that all information provided to this clinic will not be passed onto any 3rd party pursuant to the Privacy Act.

DO NOT SIGN THIS UNTIL YOU HAVE CONSULTED YOUR CHIROPRACTOR.

Patient's Signature: _____ Practitioner's Signature: _____ Date ____/____/____

¹ Halderman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: The Chiropractic experience. CMAJ 2001;165:905-906.

² Carey PF. A report on the occurrence of cerebrovascular accidents in chiropractic practice. J Can Chiropr Assoc 1993;37:104-106