9 Station St, Mitcham 3132
487 Bridge Rd, Richmond 3121
T 03 9873 7373

BetterBacks
CHIROPRACTIC & NATURAL PRODUCTS

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 Autoimmune disorders (ie, SLE, RA) 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 ->

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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?

1. On a scale 1 to 10 how would you rate your pain right now

No Pain Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10

2. Please mark your least pain (L), average pain(A) and worst pain(W) in last week:

No Pain Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10

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 the chiropractor 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 manipulations[1] and 1 in 5.8 million manipulations[2]. 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