yeronga chiropractic & wellness centre

Confidential New Patient Questionnaire

Personal Details

Title: Mr Mrs Ms Dr Mast Miss	Name:	Date:
Address:		
Suburb/Town:		Postcode:
DOB:	Email:	
Phone Hm:	Mobile:	Work:
Occupation & Employer:		
Emergency Contact:		Phone:
Keeping in touch, please confirm the ways you would like to be contacted by us: SMS reminders ☐ Email Newsletters ☐		

Referrals

How were you referred to our clinic?

Friend/Family member ☐ If so - Name: _____

Other Health Professional/Chiropractor ☐ If so - Name: _____

Yellow Pages ☐ Internet ☐ If so - Site Name: _____

Spinal Screening ☐ Corporate ☐ If so - Company Name: _____

Advertising ☐ Signage ☐

Financial

Do you have a: ☐ F/T Student or Aged Pension Card ☐ Veterans' Affairs Card ☐ Work cover Claim

Chiropractic Care

Have you ever had Chiropractic care before? Yes No

If so, when was your last visit? _____

Name of Chiropractor: _____ Suburb/Town: _____

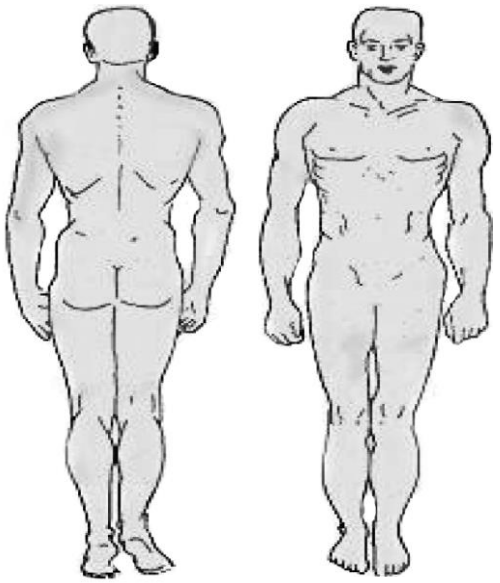
Were X-rays taken? Yes ☐ No ☐ How long ago? _____ Where? _____

How would you rate your results? Excellent ☐ Good ☐ Poor ☐

Describe your current symptoms (please be specific):_____

_____

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
Routine
Exercise

What makes your symptoms better? _____

What makes your symptoms worse? _____

When did your symptoms start? _____

Are they getting worse? ☐ Yes ☐ No

Has this occurred 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 problems, such as:
(Please circle 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/Diarrhea	Ringing in ears
Pain at night/during sleep	Unexplained weight loss/gain	Heart/blood pressure problems

Please list any other health concerns: _____

Are you taking any medication? If so, 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?

3mth _____ On-going _____

Thank you for taking the time to fill out this form

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. 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 (approx. 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.]

If you have any questions related to the treatment that you 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 from Yeronga Chiropractic. I understand that I can withdraw my consent at any time.

Please note we have a missed appointment / late cancellation fee of $30. Out of consideration to the practice and to our other patients wanting appointments, please contact us at your earliest convenience should you need to cancel or reschedule your appointment.

Date _____

Patient's Signature _____

Print Name _____

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

If female, could you be pregnant? Yes **No**

Chiropractor's Signature_____

Dr Aidan McGuigan B.App.Sc (Clinical Science) B.Chiro.Sc

Dr Lucinda Smith B.Sc(Chiro) / M.Chiro