ROF date: Special: Entered Capable:

WELLBEING CHIROPRACTIC

INITIAL ASSESSMENT FORM *CONFIDENTIAL

PERSONAL DETAILS:

Full Name:				**Date Of Birth:**	
Address:				**Suburb:** **Postcode:**	
Phone # (home):		**Mobile:**		**Work:**	
Spouse / Partner Name:		**No. Children**			
Email address				**Occupation:**	
Private insurance Health Fund:				**Chiropractic cover?**	**Y / N**
Emergency Contact:				**Emergency's Phone #**	
How did you find us? (please circle)	**Walking/Driving past Yellow Pages Google Flyer Website Newsletter Referral** **Who can we thank for referring you?**				
Previous Chiropractor	**Yes / No**	**Who?**		**When?**	**Did it help? Y / N**
Have you had SPINAL X-Rays ?		**YES / NO**		**If yes, when?**	
Rate your POSTURE out of 10? (10–1, Excellent - Poor)		**Height (cm):**		**Weight (kg):**	

MEDICAL & GENERAL HEALTH HISTORY:

Are you PREGNANT?		**If yes, how many weeks?**			
List current MEDICATIONS					
Any personal history of serious disease?					
Please list SURGERIES (incl. yr)					
Avg length of SLEEP / night?		**Age of MATTRESS?**		**Age of PILLOW?**	

STRESSES

Physical (falls, accidents, work posture) =
Bio-chemical (smoke, diet, drugs/alcohol) =
Psychological, Emotional (work, financial, relationship stresses) =

GENERAL SYSTEM REVIEW

(Tick Left box = Past symptoms, Right box = Current symptoms)

□ □ Pins & Needles, Numbness, Weakness
□ □ Soreness in Neck
□ □ Dizziness/Light-headed/Vision problems
□ □ Headaches
□ □ Painful/Clicking Jaw
□ □ Shoulder Pain/Stiffness/Tension
□ □ Mid Back Pain/Tension
□ □ Pain in Ribs or Chest
□ □ Low Back Pain/Weakness/Stiffness
□ □ Hip Pain/Stiffness, Buttock & Leg Pain
□ □ Pain on Straining/Coughing/Sneezing
□ □ Diabetes, kidney disease or heart disease
□ □ Knee/Foot/Ankle trouble
□ □ Unexplained weight loss
□ □ Leg/Muscle Cramps
□ □ Arm/Elbow/Wrist/Hand Pain
□ □ Stroke (TIA)
□ □ Loss of Smell/Taste
□ □ Allergies, Colds & Flu
□ □ Fatigue
□ □ Loss of Grip
□ □ High/Low Blood Pressure
□ □ Smoker (___/day)
□ □ Medical devices and implanted devices such as intra- cranial aneurysm clips, cardiac pacemaker, coronary stents, intra ocular foreign bodies and cochlear implants (circle relevant)
□ □ Asthma/Coughing
□ □ Ear Disorders
□ □ Freq loose stools
□ □ Cancer
□ □ Nausea/Vomiting
□ □ Menstrual issues
□ □ Diarrhoea/Digestion
□ □ Constipation
□ □ Abdominal Pain
□ □ Drink Alcohol(/ wk)

REASON FOR YOUR VISIT :

List COMPLAINTS	When did this BEGIN?	SEVERITY? Mild=1 Severe=10	HOW did this begin?	Have you had this BEFORE?	What makes this complaint WORSE?	What other TREATMENT have you had for this?
1.						
2.						
3.						
4.						

If you have no symptoms or complaints and are here for chiropractic wellness services, please write "WELLNESS CHECK UP"

CONSENT FORM

We are firmly committed to safety and efficiency at our practice. Spinal manipulation and massage is a complex clinical skill and will only be performed by a suitably qualified professional or intern under clinical supervision. We endeavour, through professional conferences, journals and continuing education to maintain the highest standards of care. In any clinical or medical procedure that deals with people there are inherent risks. Complications of spinal manipulation and soft tissue therapy when performed correctly and appropriately are extremely low in comparison to any other form of treatment. There is a possibility (figures suggest one chance in two million) that spinal manipulation of the cervical spine (neck) may be associated with damage (major or minor) to the blood supply of the brain (stroke). As an indication of comparative risk there is an accepted figure of sudden death under general anaesthesia of one in ten thousand; death caused by prescription anti-inflammatory drugs is 3,300 times more likely than spinal manipulation. Other risks associated with spinal manipulation and soft tissue therapy may relate more specifically to your condition or aggravation to the spinal structures themselves such as the bones and ribs (a possibility of fracture) or the discs, ligaments or nerves. We ask your cooperation in keeping us fully informed of your symptoms, past illnesses and any changes in your medical history including medications. Wellbeing Chiropractic uses twenty-four hour video surveillance within the clinic for internal communication and logistics. This surveillance will always be private and never shared with outside parties. If you have any queries or concerns please feel free to discuss these with us at any time. I have read and understood this informed consent form, and understand I may choose to have no treatment or alternate treatment for my condition. I hereby consent to chiropractic treatment and/or soft tissue therapy at our practice. I understand that I may withdraw my consent at any stage. I have had the opportunity to discuss this consent form and proposed treatment with the chiropractor/remedial massage therapist. Furthermore, x-rays may be taken to better assess your condition. The proposed diagnostic imaging procedure has been explained to me in full and I have had the opportunity to ask questions. FINANCIAL RESPONSIBILITY: I understand that accounts are due at the time of service. If outstanding accounts are not paid and additional services are required to recover the outstanding funds due, we reserve the right to charge a minimum administration fee of $119 plus any additional fees and charges incurred in recovering fees. OUR PRIVACY COMMITMENT: All information provided to our chiropractors and support team is confidential and will only be used by and available to your practitioner.

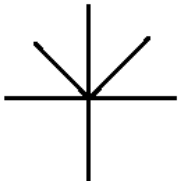
Signature…… Date: ……../……../……..……...

Name (please print) …… Doctor's Signature:

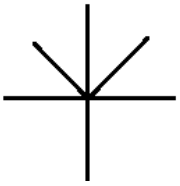
OFFICE ONLY:

SLR + / - Kemps + / - Valsalva + / - Slumps + / - Cx compression + / - Max compression + / -

Maignes + / - Tx AP compression + / - ROM Cx



Tx



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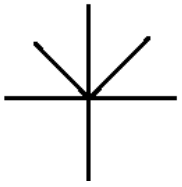

ACT	MAN	AO	DP

P:

S: