Care Chiropractic Qld
Because we care

CONFIDENTIAL PATIENT INFORMATION FORM

Mr / Mrs / Miss/ Ms / Other: ..... Date: .....

Surname ..... First Name ..... Preferred Name .....

Postal Address .....

Residential Address .....

Telephone: H ..... Mob: ..... W: .....

Date of Birth ..... Age ..... Email: .....

Occupation: ..... Employer:: .....

Partner Name: ..... Children Names:: .....

I have been referred to this office by Dr/Mr/Mrs: ..... Family/Friend/Social Media/Internet/Other

I have had previous chiropractic care by Dr: ..... in year: .....

Emergency contact (if other than partner) Name: ..... Phone: .....

Medical Doctor: ..... Address/PH: .....

Is this a WorkCover, CTP, CDM or DVA case? Yes / No (If yes please notify the front desk staff)

Reason for today's consultation .....

How long have you had this problem? .....

Is the problem (Please circle) *getting better*, *worse* or *staying the same*?

What makes it better? (Please circle) *Sitting Standing Movements such as* ..... *Other* .....

What makes it worse? (Please circle) *Sitting Standing Movements such as* ..... *Other* .....

Other problems I am concerned with: .....

.....

Accidents and Injuries including dates? .....

.....

.....

Operations? .....

.....

Sporting and exercise programs? .....

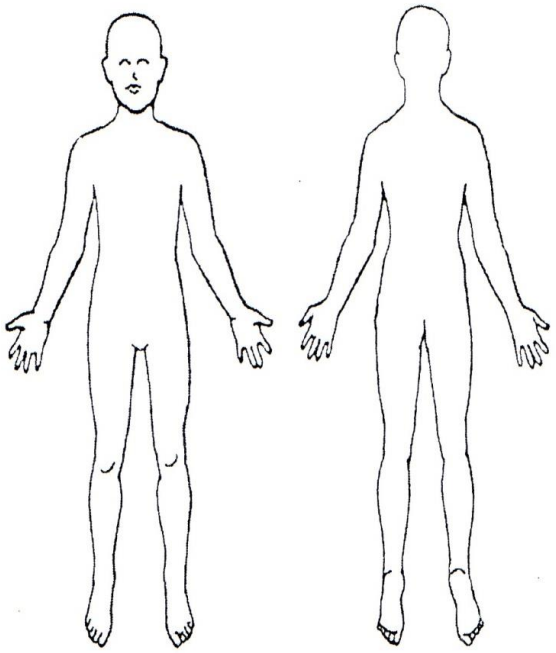
.....

Drugs/Medication/Vitamins – Type/Dosage etc? .....

.....

.....

Mark areas of concern including any radiating symptoms



Are you suffering from any of the following currently or in the past? - Tick appropriate boxes

New	*Old*		*New*	*Old*		*New*	*Old*	
☐	☐	Pins & Needles of Hands	☐	☐	Pain in Head	☐	☐	Asthma
☐	☐	Loss of Grip	☐	☐	Soreness in Neck	☐	☐	Chronic Cough
☐	☐	Wrist or Hand Pain	☐	☐	Shoulder Pain	☐	☐	Stomach Tension
☐	☐	Mid Back Pain	☐	☐	Shoulder Stiffness	☐	☐	Digestive problems
☐	☐	Mid Back Tension	☐	☐	Shoulder Tension	☐	☐	Nausea
☐	☐	Pain in Ribs	☐	☐	Arm Pain	☐	☐	Allergies
☐	☐	Low Back Pain	☐	☐	Elbow Pain	☐	☐	Vomiting
☐	☐	Low Back Weakness	☐	☐	Loss of Arm Power	☐	☐	Constipation
☐	☐	Low Back Stiffness	☐	☐	Eye Disorders	☐	☐	Diarrhoea
☐	☐	Hip Pain or Stiffness	☐	☐	Loss of Taste	☐	☐	Abdominal Pain
☐	☐	Buttock Pain	☐	☐	Headaches	☐	☐	Piles
☐	☐	Leg Pain	☐	☐	Nervousness	☐	☐	Urinary Disorders
☐	☐	Leg Cramps	☐	☐	Insomnia	☐	☐	Bed Wetting
☐	☐	Pins & Needles of Legs	☐	☐	Dizziness	☐	☐	Menstrual Disorders
☐	☐	Knee Trouble	☐	☐	Loss of Smell	☐	☐	Loss of Potency
☐	☐	Foot or Ankle Trouble	☐	☐	Sinus Trouble	☐	☐	Other Sexual Disorder
☐	☐	Pins & Needles of Feet	☐	☐	Ear Disorders	☐	☐	Tension
			☐	☐	Hay Fever	☐	☐	Excessive Irritability
			☐	☐	Recurrent Sore Throat	☐	☐	Lacking energy
						☐	☐	Sleeping Problems

What are your health goals?
[ ] Symptom relief only
[ ] Symptom relief & correction of their underlying cause
[ ] Optimal health of the spine & body now & in the future
[ ] Other .....

Consent for Chiropractic Care

Doctors of Chiropractic, who use manual techniques such as spinal adjustments, are required to advise patients that there are some risks associated with such care. While rare, it has been documented that some patients have experienced the following complications following a spinal adjustment: general soreness/stiffness, muscle strain, ligament sprains, osteoporotic rib fractures and disc injury (less than 1 in 3.7 million) [1]. Current research surrounding the issue of stroke and chiropractic care has demonstrated that there is no evidence of excess risk of injury to the vertebrobasilar artery in comparison to visiting your medical doctor or another primary care provider[2].

When delivered by a registered chiropractor, the risk of injury or complications from an adjustment is substantially lower than those associated with many medications and procedures used for similar conditions. Your chiropractor will conduct a thorough examination to determine the most appropriate procedure for you.

Posture photos will be taken for clinical and identification purposes only.

Should you wish to discuss this consent clause further with the chiropractor, please don't hesitate to inform the Front Desk staff.

[ ] I consent to chiropractic care recommended to me by my chiropractor, including spinal adjustments & associated advice. I intend this consent to apply to my present and all future chiropractic care.
[ ] I consent to be contacted via email for Appointment Reminders, Workshop Announcements and Educational Material purposes. Care Chiropractic Queensland will not, in any circumstance, share your personal information with other individuals or third party organisations without your permission, except when applicable by law.

1. Drew Olphant (2004) *Safety of Spinal Manipulation in the Treatment of Lumbar Disk Herniation: A Systematic Review & Risk Assessment*, JMPT 27(V3): 197-210
2. Cassidy JD, Boyle, E, Cote et al (2008) *Risk of Vertebrobasilar Stroke & Chiropractic Care: Results of a Population-Based Case-Control & Case-Crossover Study,* Spine 33(4S): S176-183

Date:…….....

Patient Signature:……

Chiropractors Signature:……