Helensvale Chiropractic

Welcome to helensvalechiropractor.com

Please take a few minutes to fill out this form as completely as you can.
All details given here are for use within the clinic and are confidential.
If you have any questions, please do not hesitate to ask.
We look forward to working with you in maintaining your health.

OFFICE USE ONLY
Patient for:
___ Dr _____
___ Dr _____

NAME: Miss / Ms / Mrs / Mr _____ (FIRST) _____ (MIDDLE INITIAL) _____ (SURNAME) Preferred Name: _____

POSTAL ADDRESS: _____ Postcode: _____

HOME PHONE No: _____ MOBILE: _____ EMAIL: _____

DATE OF BIRTH: ___ / ___ / _____ OCCUPATION: _____

SPOUSE NAME: _____ NUMBER OF CHILDREN: _____

HAVE ANY OF YOUR FAMILY MEMBERS HAD CHIROPRACTIC CARE BEFORE: ☐ YES ☐ NO

DO YOU HAVE PRIVATE HEALTH THAT COVERS CHIROPRACTIC CARE: ☐ Yes – Insurer _____ ☐ No ☐ Not Sure

Most of our patients are referred to us by caring family or friends. How were you referred to this office?

☐ Family/Friend Name: _____

☐ Google ☐ Internet ☐ Web Site ☐ Signage ☐ Yellow Pages ☐ Yellow Pages On-Line
☐ White Pages ☐ Newspaper ☐ Mailbox Drop ☐ True Local ☐ Facebook ☐ Twitter
☐ Shopping Centre ☐ Other: _____

If you have ever had Chiropractic care before, please complete the following:

NAME OF CHIROPRACTOR: _____ LOCATION: _____

WHAT WERE YOU BEING TREATED FOR? _____

No. OF TREATMENTS PROVIDED? _____ HOW OFTEN? _____ WHEN WAS YOUR LAST TREATMENT? _____

DID THE CHIROPRACTOR HAVE X-RAYS TAKEN? ☐ Yes ☐ No ☐ Can't remember

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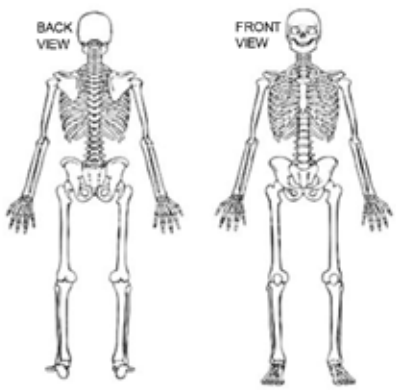
Reason for this visit:



WHAT IS YOUR REASON FOR **THIS VISIT**? _____

_____

IF YOU HAVE PAIN, WHAT IS THE FREQUENCY OF PAIN: _____

DESCRIBE LOCATION OF THE PAIN or INDICATE ON THE DRAWING:

_____

_____

_____

WOULD YOU DESCRIBE THIS PAIN AS: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____

ARE YOU EXPERIENCING: ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Cramping ☐ Tingling ☐ Spasms

ARE ANY OF THE FOLLOWING DIFFICULT/PAINFUL: ☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Running/Jogging
☐ Lying down ☐ Lifting ☐ Other _____

APPROX. DATE SYMPTONS BEGAN? _____ HAVE YOU HAD SIMILAR SYMPTONS BEFORE ☐ Yes ☐ No

IS THE PAIN GETTING: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes

HAVE YOU BEEN TREATED BY A HEALTH CARE PRACTIONER FOR THIS CONDITION BEFORE TODAY? ☐ Yes ☐ No

IF YES WHAT TYPE: ☐ Medical Doctor ☐ Chiropractor ☐ Physiotherapist ☐ Masseuse ☐ Other _____

Health History:

IN THE LAST 10 YEARS HAVE YOU HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITION:

☐ Arthritis	☐ Wrist pain	☐ Artificial joints/limbs	☐ Diabetes	☐ Headache
☐ Scoliosis	☐ Lower back pain	☐ Cancer	☐ Gout	☐ Migraine
☐ Neck pain	☐ Sciatica	☐ Stroke	☐ Asthma	☐ Dizziness
☐ Jaw pain	☐ Leg pain	☐ Heart attack	☐ Respiratory disorders	☐ Epilepsy
☐ Shoulder pain	☐ Knee pain	☐ High Blood Pressure	☐ Digestive problems	☐ Other _____
☐ Arm pain	☐ Ankle pain	☐ Appendicitis	☐ Ulcers	_____

PLEASE LIST ANY MEDICATION (INCLUDING PAIN KILLERS) YOU ARE TAKING: _____

PLEASE LIST ANY SUPPLEMENTS YOU TAKE ON A REGULAR BASIS: _____

WHEN WAS THE LAST TIME YOU DID A BOWEL OR LIVER DETOX? _____

DO YOU FIND IT DIFFICULT TO LOSE WEIGHT?: ☐ YES ☐ NO DO YOU WEAR ORTHOTICS?: ☐ YES ☐ NO

PLEASE LIST ANY SERIOUS INJURIES OR SURGERIES YOU HAVE HAD IN THE LAST 10 (TEN) YEARS:

☐ Falls	Date:_____	Details:_____
☐ Head Injuries	Date:_____	Details:_____
☐ Broken Bones	Date:_____	Details:_____
☐ Dislocations	Date:_____	Details:_____
☐ Surgeries	Date:_____	Details:_____
☐ Other Serious Injuries	Date:_____	Details:_____

PERSONAL HABITS – Please circle the most relevant level in the list below:

Alcohol Intake	Heavy / Moderate / Light / None	Sugar Intake	Heavy / Moderate / Light / None
Coffee Intake	Heavy / Moderate / Light / None	Exercise	Heavy / Moderate / Light / None
Water Intake	Heavy / Moderate / Light / None	Sleep	Heavy / Moderate / Light / None
Smoking	Heavy / Moderate / Light / None	Appetite	Heavy / Moderate / Light / None

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Women only:

Are you pregnant? ☐ Yes – if so how far along are you _____months _____ weeks ☐ No ☐ Not sure

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Patient Information:

Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug free health care profession in the world.

However, we do wish to inform you that there are some possible risks that may be associated with chiropractic care. Very rare risks may include muscle soreness, strain to a ligament or disc in the neck and lower back and aggravation of the underlying condition. Extremely rare is the risk of damage to neck blood vessels which can arise in a stroke or stroke-like symptoms. This said, **chiropractic adjustments of the spine are still internationally recognised as being far safer than medication and many other alternatives**.

If you have any questions relating to the care you are about to receive, please speak to your chiropractor.

Informed Consent:

I acknowledge the above information and do not expect the chiropractor to be able to anticipate all potential risks and complications. I have also reviewed the information I have provided and believe it to be accurate. I understand that this information will be used by the clinic to help determine appropriate treatment. If there are any changes in my medical status I will inform the clinic. Based on the information provided, I consent to receiving chiropractic and or massage care in this clinic.

CAA MEMBER

_____ _____ _____

Patient's Name (please print) Patient/Guardian Signature Date