LANE COVE CHIROPRACTIC

9428 4033
Unit 1/46 Burns Bay Rd,
Lane Cove, NSW, 2066

Today's Date: ____ /____ /____

WELCOME TO OUR PRACTICE

Full Name _____

Date of Birth ____ /____ /____ Email _____

Home Address _____

Suburb _____ Post Code _____

Phone Number _____

Occupation _____ How long in this position? _____

No. Children _____ Age/s _____

Who may we thank for referring you to this practice? _____

Your Height: _____ cm Your Weight: _____ kg

HOW CAN WE HELP YOU

What is the reason for your visit today? _____

_____

When did the problem start? _____ Do you know what caused it? _____

Have you had this problem before? _____

How often? _____ Is it getting better/staying the same/getting worse? _____

What treatments have you tried? _____

Did it help? _____

Have you had any previous chiropractic care? _____

Please note any enjoyable or important activities that you are having difficulty with as a result of your current problem:
E.g. Sporting & hobbies: golf/gym/painting
Home duties/Work: gardening/cleaning/cooking/sitting/productivity

_____

_____

Have you had any of the following:

Significant accidents/injuries ○ Yes ○ No _____

Broken bones ○ Yes ○ No _____

Hospitalisations ○ Yes ○ No _____

Operations ○ Yes ○ No _____

Are you currently taking any medications? _____

Please mark below:

◯ Yes	◯ No	Smoker
◯ Yes	◯ No	Alcohol
◯ Yes	◯ No	History of cancer
◯ Yes	◯ No	Unexplained weight loss in the last 4 wks
◯ Yes	◯ No	Pain in the upper back or chest at night
◯ Yes	◯ No	Systemically unwell
◯ Yes	◯ No	Pins and needles in both hands and/or feet
◯ Yes	◯ No	Trauma: fall from height/road traffic accident/combat
◯ Yes	◯ No	Past medical history of tuberculosis or osteoporosis
◯ Yes	◯ No	Recent change in bowel or bladder function

PATIENT INFORMATION & INFORMED CONSENT

All practitioners who manipulate the spine are required to warn patients of material risks associated with the procedures they apply. Whilst these risks are rare, they include but are not limited to disc injuries (aggravation of existing disc condition), muscle strain, costovertebral (rib) strains or an aggravation of presenting symptoms, nausea and /or dizziness. In very rare circumstances, (less than 1:1 million) some treatments of the neck have been suspected of damaging a blood vessel and giving rise to stroke or stroke-like symptoms, though the actual likelihood of this taking place is unknown. (Systematic Review and Meta-Analysis of Chiropractic Care and Cervical Artery Dissection: No Case for Causation. Church et al. 2016)

Some patients with bone weakening diseases may require techniques to be modified to avoid the rare possibility of rib or spine fracture and some patients may experience stiffness and/or soreness in the first few days following treatment. If you are aware of anything which you feel should be taken into consideration regarding the treatment of your condition, please bring it to our attention.

The procedures to be used in your case will be described after which you will be asked if you have any questions. After speaking with the chiropractor, we request that you sign below as your consent to proceed is required for both examination and treatment procedures. The treatment modalities used in this practice are based around manual techniques and spinal adjustment (specific manipulation). However, there are a range of treatment options we may use or refer you for which include, traction, mobilization, remedial massage and acupuncture or medication. Feel free to discuss treatment options with us. Please note there may be a considerable degree of variation in individual patient response and results are not guaranteed.

Patient's Signature:_____ Print Name: _____

Chiropractor's Signature: _____ Date: ____ /____ /____

Are you happy for us to report to your GP regarding your treatment if we and/or you feel it to be necessary? ◯ Yes ◯ No

GP Name: _____ Phone: _____

Are you happy for us to communicate with you by email if necessary? ◯ Yes ◯ No
Note: We will never use your email address for any advertising or subscriptions.

Emergency Contact Name: _____ Phone: _____