

WELCOME TO OUR PRACTICE

Date: _____

NAME _____ BIRTH DATE: (DD/MM/YYYY) _____ SEX: M / F
ADDRESS _____ POST CODE _____
HOME PHONE _____ MOBILE _____ WORK _____
EMAIL _____
OCCUPATION _____ PRIVATE HEALTH: _____
HOW DID YOU HEAR ABOUT US: SIGN / YELLOW PAGES / WEBSITE / OTHER: _____
IS THIS A WORKER'S COMPENSATION CLAIM? _____ CLAIM NO. _____
IS THIS A MOTOR VEHICLE ACCIDENT CLAIM? _____ CLAIM NO. _____
FAMILY DOCTORS NAME AND ADDRESS _____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting people to function optimally, to become more self aware, healthier, stronger, and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional, and chemical stresses that can gradually overwhelm the body and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box)

Health Concern _____

What happened? _____

When did you notice it? _____ How often does it occur? _____

Is it getting better, getting worse, or staying the same _____

If pain is involved, rate it on a scale of 1 to 10 (1 is minimal, 10 is extreme) _____

Circle or describe it's character: Sharp / dull / ache / burning / tingling / throbbing / spasms

What relieves? _____ What aggravates _____

Does it radiate or cause problems somewhere else? _____

Any associated or related concerns? _____

Other professionals seen for this _____

Treatment and results _____

Has this occurred before? _____ When? _____

What caused it in the past? _____

For women: Are you pregnant? Yes / No / Unknown if yes how many weeks? _____

Disease history: (please circle any condition you have, or have had in the past)

Allergies / Lowered resistance / Dizziness or lightheadedness / Loss of balance / Fatigue
Frequent colds / Difficulty concentrating / Indigestion / Heartburn / Bloating / Appendicitis
Asthma / Bronchitis / Emphysema / Pneumonia / Bleeding disorders / Cancer / Cataracts,
Vision changes / Diabetes / Hypoglycemia / Epilepsy / Heart Disease / Ulcerative colitis
Headaches / Migraines / Hepatitis / High cholesterol / High blood pressure / Kidney Disease
Digestive difficulties / Constipation Loose stools / Hernia / Herniated Disc / Liver disease
Fertility problems / Miscarriage / Multiple Sclerosis / Osteoarthritis / Rheumatoid arthritis
Osteoporosis Pinched nerve / Numbness and tingling / Pins and needles / Parkinson's Disease
Tonsillitis Stroke / TIA / Prostate problems / Menstrual pain and cramping / Hypertension
Thyroid problem / Ulcers / Urinary tract infections / Other: _____

Physical stresses

Any significant injuries, falls, or traumas during infancy or childhood? **Yes / No / Unsure**

(if yes please explain) _____

Any significant injuries, falls, or traumas during adulthood? **Yes / No / Unsure**

(if yes please explain) _____

Have you had any hospital visits, surgeries, fractures, accidents? **Yes / No**

(if yes please explain and give dates) _____

Are you in prolonged postures (repetitive work, lifting, sitting, driving) **Yes / No / Unsure**

(if yes, please explain) _____

Any hobbies that are physically strenuous or have repetitive movements? **Yes / No / Unsure**

(if yes, please explain) _____

What is your usual exercise routine? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? **Yes / No** (if yes please explain what happened and when) _____

Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No** (if yes, which ones and why) _____

Are you currently taking supplements? **Yes / No** (if yes, which ones and why) _____

Do you smoke? **Yes / No / Quit** (if yes how much?) _____

Do you drink? **Yes / No** (if yes roughly how much?) _____

Do you take recreational drugs? **Yes / No** (if yes which ones and how much?) _____

Do you drink caffeinated drinks? **Yes / No** (if yes how much?) _____

How much water do you drink each day? _____

Are you exposed to pollutants, chemicals, aerosols? **Yes / No / Occasionally**

Mental/Emotional Stresses - As psychological stress has been shown to negatively affect many systems, please let us know how you are coping with life's stresses.

Please rate the following from 1 to 10 with 1 being minimal to 10 being extreme: Relationships _____

Life in general _____ Work and Career _____ Finances _____ Health/well-being _____ Sleep quality _____

If you are experiencing significant or ongoing stress please explain _____

Do you practice some form of meditation, breath work, or have a routine to reduce your stress?

Yes / No (if yes explain?) _____

Are you interested in learning about stress reduction practices? **Yes / No**

Family Health History

Please note any health issues that are present with family members such as parents, brothers, sisters, or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other _____

Why are you here? - People seek chiropractic care for a number of reasons and have certain expectations and perceptions.

Please tick the goals which apply to you so we can accommodate your wishes:

Improvement in function Pain reduction Longevity Improved quality of life Relief

Manage my crisis Information on prevention Healthier immune system Optimum function and quality of life Symptom management Stress reduction Keep me moving Improved performance Full body integration Wellness Other: _____

Patient name: _____ **Date:** _____

FINANCIAL policy: I understand Quest Chiropractic does not hold accounts. I am personally responsible for the full payment of all fees incurred. Patient Signature: _____

CONSENT for examination: Please Read Carefully

In order for my Chiropractor to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do request and consent to the performance of such an evaluation by the chiropractor named below, or any party authorized to do so by that person. I have had the opportunity to discuss with the Doctor of Chiropractic or with any party authorized to do so, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. I understand that I may ask the doctor to stop the examination at any time. I also understand that the Chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date: _____

Signature: _____ Witness: _____

INFORMED CONSENT for chiropractic care: Please Read Carefully

It has been determined that my case is suitable for chiropractic care.

After my report of findings, I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, osteopaths, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing, sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately **1 in 1 million**. To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

- Risk of paralysis or stroke from surgeries or neck pain **15,600 per 1 million**
- Risk of death from surgery for neck pain **6,900 per 1 million**
- Risk of serious gastrointestinal event from a non-steroidal anti-inflammatory drug (e.g. Aspirin, ibuprofen) **1,000 per million**
- Risk of stroke following a chiropractic adjustment **1 per 1 million up to 1 per 5 million**

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is **1,677 per 1 million**, and annual risk for being injured in a car accident is **13,333 per 1 million**.

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is uniquely trained to assess your spine and adjust in ways that significantly diminish your risk.

I have read and understood the remote risks inherent in undergoing chiropractic care, and do not expect the Chiropractor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Chiropractor to exercise judgment during the course of chiropractic care on that basis.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may still ask questions to the Doctor at any time after I sign this consent. I understand that my consent can be withdrawn at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Signature: _____

Witness: _____ Discussed Date: _____

Doctors of Chiropractic: Dr Jennifer Thomson, Dr Alicia Hill
Quest Chiropractic 1/15 Roopena Street, Ingle Farm, SA, 5098