A: Shop 402, 326 Camden Valley Way, Narellan NSW 2567
P: (02) 4648 0022
E: admin@proactivespine.com.au
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CHIROPRACTIC NEW PATIENT FORM

Personal Details

Name: Dr/Mr/Mrs/Ms ____

Address: ____

______________________________ Postcode: ______________________

Phone Home: ______________________ Phone Mobile: ______________________

Email: ______________________ Occupation: ______________________

Date of Birth: ______________________ Age: ______________________

Marital Status: M / S / D / W No. of Children: ______________________

Emergency Contact Details: ____

How did you find out about us? ____

Do you belong to a Health Fund? Yes [ ] ______________________ No [ ]

Is this related to a Workers Compensation [ ] or Third Party Claim [ ] ? No [ ]

Who is your regular doctor (General Practitioner)? ______________________________

Have you seen a Chiropractor before?

Yes [ ] Name of previous Chiropractor ______________________ Date of Last Adjustment __________

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Major Concern

What is your main problem/concern? ____

When and how did it start? ____

Is it Getting Better / Worse / Same ? (Circle one)

What makes it better? ____

What makes it worse? ____

Does the pain travel down your arms or legs? Yes / No ______________________________

Have you had any other treatment for your current problem? Yes / No ______________________

____

Previous Medical History

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No ____

____

Have you had any form of surgery? Yes / No ______________________________

____

Are you currently taking any form of medication? Yes / No If yes list all of them ______________

____

Have you had any broken bones? Yes / No If yes, which ones and how? ___________________________

____

Have you had any major accidents or falls? Yes / No If yes, when and describe ______________________

____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No ______________________________________

____

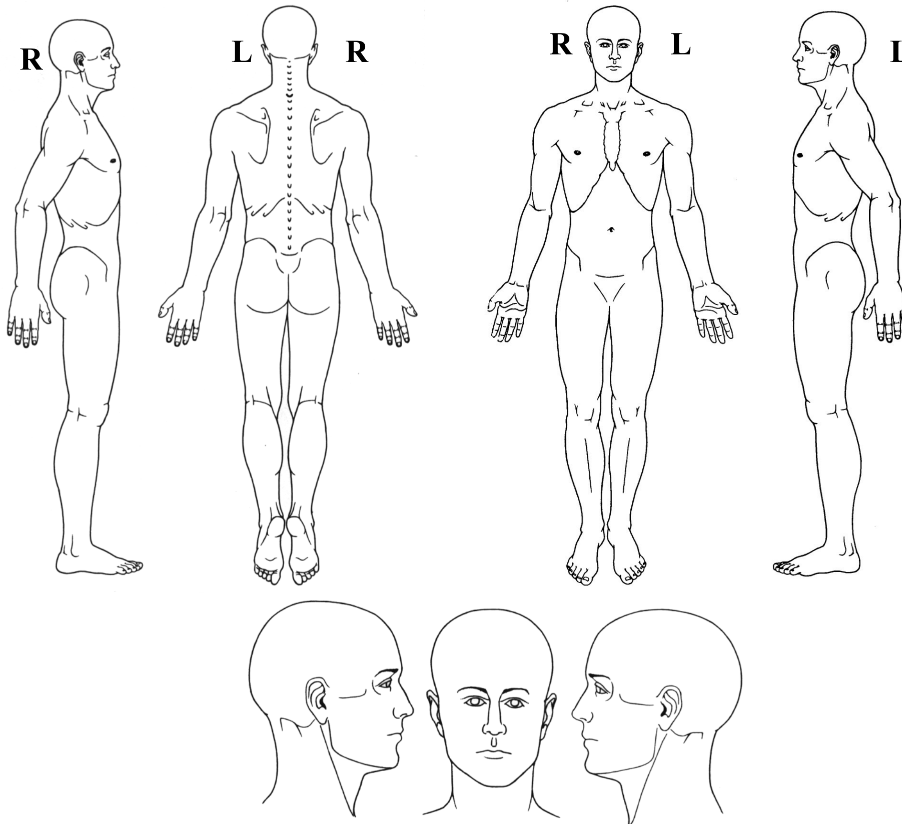
Do you suffer with any of the following? (please tick)

Dizziness [ ] Unexplained Weight Loss [ ] Loss of Bowel/Bladder Control [ ] Night Sweats [ ]
Headaches[ ] Recent history of cancer [ ] Sudden loss of consciousness [ ] Visual Changes [ ]

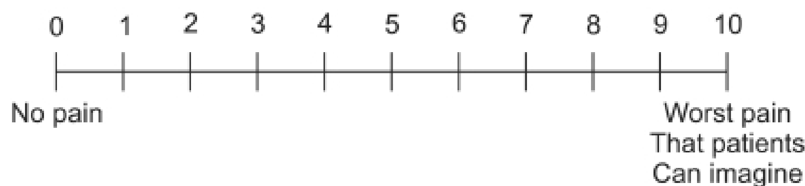
Do you (please tick)

Smoke [ ] Consume Excessive Alcohol [ ] Use Recreational Drugs [ ]

Please mark on the diagrams below any areas of discomfort or concern



Please mark on the scale what you would rate your pain?



Do You Have any Questions or Concerns? ____

____

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CONSENT TO CHIROPRACTIC CARE

Chiropractic care and other techniques used at **Proactive Spine & Sports Medicine** are well recognized as being extremely safe health care interventions for people of all ages. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully:

I acknowledge that I have discussed with **the chiropractor** the rare risks associated with my proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) (estimated at less than 1 per million); and an exacerbation and/or aggravation of my underlying condition.

I have had the opportunity to discuss the proposed care with **the chiropractor.** I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
I also understand that there are alternatives to the proposed treatment including no treatment, medicine prescribed by general practitioner, physiotherapy and the chiropractor has discussed other alternatives which may be relevant to my condition.

I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

I hereby acknowledge my consent to the performance of the proposed chiropractic care by **the below mentioned chiropractor** and/or any other chiropractor working at **Proactive Spine & Sports Medicine**. I understand that I can withdraw consent at any time.

We understand that you may need to cancel your appointment occasionally. Please note that cancelations require at least 6 hours notice prior to your appointment. Please be advised that if a 6 hour cancellation notice is not met, or you have not shown up to an appointment you may be required to pay a cancellation fee of 50% before your next appointment.

....
Patient's signature
(Parent or Guardian to also sign if patient is under 18)

.... Dated: ....
Patient's Name (printed)

.... Dated: ....
Chiropractor's Name & Signature