yeronga chiropractic & wellness centre

Confidential New Patient Questionnaire

Personal Details

Title:	Name:	Date:
Address:		
Suburb/Town:		Post Code:
Date of Birth:	Email:	
Home Phone:	Mobile:	Work Phone:
Occupation and Employer:		
Emergency Contact:		Emergency Phone:
Regular GP Details:		
Keeping in touch. Please confirm the way you would like to be contacted by us:	☐ SMS	☐ Email

Referrals

How were you referred to our clinic?

- ☐ Friend/family member — If so – Name:
- ☐ Other health professional/Chiropractor — If so – Name:
- ☐ Internet
- ☐ Spinal Screening
- ☐ Signage
- ☐ Advertising

Financial

Do you have a:

☐ F/T Student or Pension card ☐ Veteran Affairs Card ☐ Work Cover Claim

Chiropractic Care

Have you ever had Chiropractic care before? ☐ Yes ☐ No

If so, when was your last visit?

Name of Chiropractor: Suburb/Town:

How would you rate your results: ☐ Excellent ☐ Good ☐ Poor

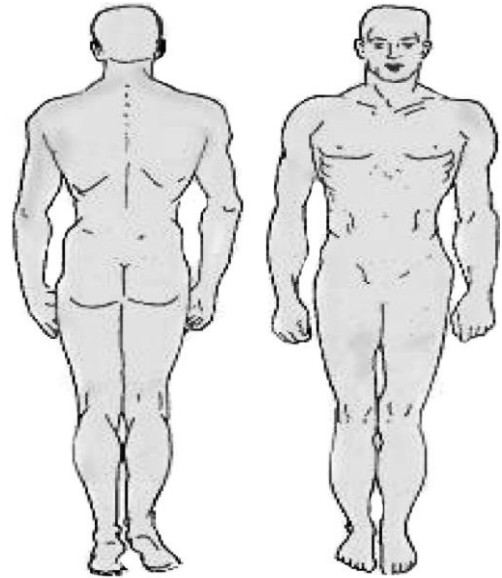
Have you had any of the following investigations done of your spine or relevant problem areas?

- ☐ X-Ray — If so – where and when?
- ☐ MRI — If so – where and when?
- ☐ CT Scan — If so – where and when?

Further Investigations

Describe your current symptoms.
(please be specific):

Please indicate the area(s) of discomfort on the diagram (on right)



Please indicate the severity of discomfort you are experiencing right now:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No Pain   Discomfort   Very Sore   Extreme Pain

Does your condition interfere with:
- ☐ Work
- ☐ Sleep
- ☐ Routine
- ☐ Exercise

What makes your symptoms better?

What makes your symptoms worse?

When did your symptoms start?

Are they getting worse? ☐ Yes ☐ No

Has this occurred before? ☐ Yes ☐ No

If so, when did this occur?   How often?

Do you know what caused it?

Have you ever received any treatment for this condition? If so, please list:

Was it effective? ☐ Yes ☐ No

General Health

A poorly functioning spine and nervous system can affect the way your entire body functions. Are you experiencing any other health problems, such as:
(If applicable, please tick appropriate box for occasionally 'O', or frequently, 'F'.)

Headaches/ Migraines	O ☐	F ☐	Asthma/ Problems breathing	O ☐	F ☐	Muscle weakness	O ☐	F ☐
Double/ Blurred vision	O ☐	F ☐	Cold/Painful Extremities	O ☐	F ☐	Fever/Nausea	O ☐	F ☐
Indigestion/ Heartburn	O ☐	F ☐	Dizziness/ Loss of balance	O ☐	F ☐	Painful cough/ sneeze	O ☐	F ☐
Tingling/ Numbness	O ☐	F ☐	Heart/blood pressure problems	O ☐	F ☐	Ringing in ears	O ☐	F ☐
Pain at night/during sleep	O ☐	F ☐	Unexplained weight loss/gain	O ☐	F ☐	Constipation/Diarrhea	O ☐	F ☐

Please list any other health concerns:

Are you taking any medications? If so, list:

What lifestyle activities have you had to give up due to your current health condition?

What are your health and lifestyle goals for the future?

3 months: On-going:

Thank you for taking the time to fill out this form

yeronga chiropractic & wellness centre

Informed Consent to Chiropractic Care

Chiropractic Adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 2.15 million). Other very slight risks include (but are not limited to) strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) [Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed.]

If you have any questions related to the treatment that you are about to receive, please speak to your Chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the Chiropractor and give my consent to treatment.

I understand that results are not guaranteed and that the Chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.

I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and I have been given sufficient time to make a decision giving consent for the care to proceed.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment from Yeronga Chiropractic.

I understand that I can withdraw my consent at any time.

Please note we have a missed appointment / late cancellation fee of $30. Out of consideration to the practice and to our other patients wanting appointments, please contact us at your earliest convenience should you need to cancel or reschedule your appointment.

INDIGO SOUL MEMEBERS ONLY

☐ Following a discussion with my treating clinician, I consent to relevant information being shared between my practitioners as it pertains to co-management for which I am seeking care.

Please do not sign until you have spoken to your Chiropractor.

If female, could you be pregnant ☐ Yes ☐ No

Date:	
Patient's Name:	
Patient's Signature:	
Parent/Guardian Signature: **(if patient is under 18yrs)**	
Chiropractor's Signature:	

Dr Aidan McGuigan B.App.Sc (Clinical Science) B.Chiro.Sc

Dr Lucinda Smith B.Sc(Chiro) / M.Chiro