

FEMALE ADULT PATIENT (18 – 60 years)



N.B. Your information is handled in line with the current privacy regulations

Date: _____

Surname:		Date of Birth:	
Given name / s:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Marital Status:	
Year of birth of any children:			
Email Address:			
Residential Address:			
Postcode:			
<u>Home Phone:</u>	<u>Work Phone:</u>	<u>Mobile Phone:</u>	<u>Emergency Contact Name and Number:</u>
Private Health Fund:			
GP name and address:			
Permission to contact your GP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Who may we thank for referring you?		Have you viewed our website: <input type="checkbox"/> Yes <input type="checkbox"/> No www.uminachiropractic.com.au	
Occupation:		Do you commute? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, hours per day: _____ hours	
		How many hours are you seated per day: _____ hrs	

As a courtesy we endeavor to send SMS reminders the day before your appointment, however, please note it is still your responsibility to be aware of your appointment date and time. If this is not appropriate for you, please advise reception. For information on our cancellation policy, please speak to reception staff.

Today I am attending for...

Have you ever seen a Chiropractor before?

- Yes If YES what for? Wellness / lifestyle / nerve system health care
 Symptom based - neck pain / back pain
- No Not to worry... We will explain Chiropractic Care to you!!

Please inform us of your short and long term health goals:

CURRENT HEALTH CONCERNS

What are your current symptoms:	When did this start?	How did this start?
Have you previously had these symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how long ago: _____		
Since starting, have the symptoms:	<input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Stayed the same? Please briefly explain: _____ _____	
What treatment / s have you tried:	Has this helped the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____	
	What else improves / worsens the condition:	
	What does this condition affect: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Sports <input type="checkbox"/> Daily routine <input type="checkbox"/> Exercise <input type="checkbox"/> Other _____	
Please rate the intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10 Best Worst		

Describe your current Symptoms:

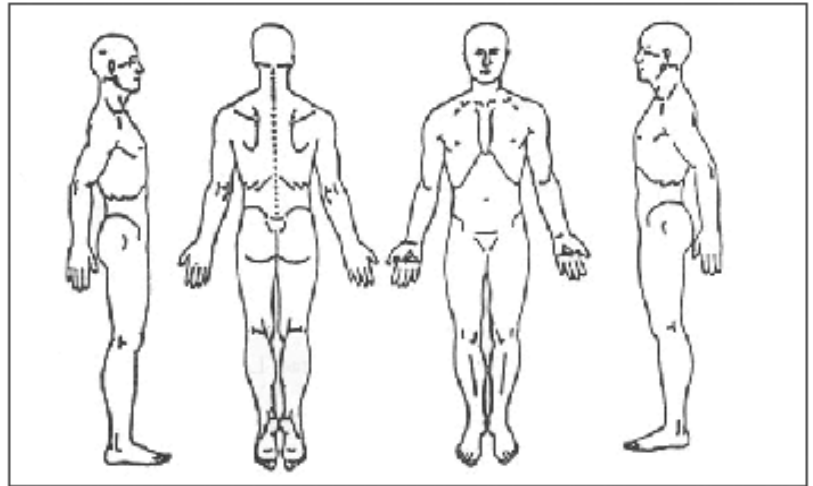
- | | |
|------------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Shooting pain |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other _____ |

Please indicate on the diagram below where your symptoms are:

Pain = X

Tingling/numbness = ///

Shooting/Radiating = >>>



HEALTH HISTORY

Please Tick the following conditions YOU have had or have now *(tick and please write approx. year)*

Please write the year / s on the line provided			
<input type="checkbox"/> sinus problems _____	<input type="checkbox"/> miscarriage _____	<input type="checkbox"/> constipation _____	<input type="checkbox"/> muscle cramps _____
<input type="checkbox"/> headaches _____	<input type="checkbox"/> menstrual cramps _____	<input type="checkbox"/> obesity _____	<input type="checkbox"/> anxiety/depression _____
<input type="checkbox"/> migraines _____	<input type="checkbox"/> PMS _____	<input type="checkbox"/> diarrhea _____	<input type="checkbox"/> excessive stress _____
<input type="checkbox"/> pneumonia _____	<input type="checkbox"/> irregular periods _____	<input type="checkbox"/> thyroid problems _____	<input type="checkbox"/> insomnia _____
<input type="checkbox"/> asthma _____	<input type="checkbox"/> bladder weakness _____	<input type="checkbox"/> gout _____	<input type="checkbox"/> alcoholism _____
<input type="checkbox"/> ringing in ears _____	<input type="checkbox"/> sexual dysfunction _____	<input type="checkbox"/> low blood sugar _____	<input type="checkbox"/> cancer _____
<input type="checkbox"/> stroke _____	<input type="checkbox"/> irritable bowel _____	<input type="checkbox"/> diabetes _____	<input type="checkbox"/> multiple sclerosis _____
<input type="checkbox"/> high blood pressure _____	<input type="checkbox"/> syndrome _____	<input type="checkbox"/> eczema _____	<input type="checkbox"/> other _____
<input type="checkbox"/> heart attack _____		<input type="checkbox"/> allergies _____	
<input type="checkbox"/> anemia _____		<input type="checkbox"/> arthritis _____	

Did you know that poor water consumption is commonly associated with a significant increase in pain?

Quantity

Alcohol Yes No _____ per week

Tea Yes No _____ per day

Coffee Yes No _____ per day

Water Yes No _____ per day

Soft Drink Yes No _____ per day

Smoke Yes No Previously _____ per day

Recreational drugs Yes No Previously

If yes, what sort and when _____

MEDICAL HISTORY:

Medications / Supplements	Dosage:	How Often:	How long have you been taking it for:

NB: If you have a copy of your medication list, please hand to reception on arrival or please list your medications and / or any supplements above.

<u>Accidents / Injuries / Falls</u>	When and how often:
<u>Illnesses</u>	
<u>Surgeries / Hospitalisation</u>	

Have you had previous pregnancies / miscarriages / stillbirths? Yes No
 How many: _____

Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	How many weeks gestation are you?
	Are you under GP / Obstetric care? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____
	Do you have any concerns regarding your pregnancy:

Have you had a pre – natal consult? Yes No **If so, date of last consult:**

Have you had any ultrasounds for this pregnancy? Yes No **If so, how many:**

FAMILY HISTORY: (please tick)

- | | |
|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Genetic disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart / Vascular disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Spinal curvature | |

LIFESTYLE CONCERNS

Please fill in the information below so that your Chiropractor can assess the accumulation of stressors on the body that affects your health and ability to heal.

On a scale of 1-10 please rate your:

Eating Habits:

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Movement Habits (Eg. exercise, exercising posture & sport)

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Sleeping Habits

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Home Life

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Work

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Anxiety /stress regarding your lifestyle (Eg. Finances, relationships, etc)

0 1 2 3 4 5 6 7 8 9 10
High anxiety / stress none

Happiness

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Thank you for taking the time to fill in this important information about your health and wellbeing. We look forward to assisting you in achieving your optimum health and maintaining a happy and abundant life.

INFORMED CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, changes to the law now require all chiropractors to warn people of material risks.

As in all health care, there are some risks with chiropractic care. This includes, but is not limited to:

Your condition becoming worse;

- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back);
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments)
- Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs and safer than driving a car.

Some people may experience some mild soreness for 24-48 hours after their adjustments, especially when their body is unwinding. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates **unexpected improvement** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health. Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system
- 14% circulatory system/heart;
- 14% eyes/vision.

Paediatric Chiropractic Care. I agree to the Chiropractors at the Umina Chiropractic Centre delivering chiropractic care to minors under my care at my instruction. I understand that these chiropractors are not paediatricians; but are qualified to manage chiropractic care in children. I am also aware that these same chiropractors are members of the Chiropractors Association of Australia and are registered health care practitioners under the AHPRA (Australian Health Practitioners Regulatory Authority). The practitioners maintain their competencies by continuing professional development.

Consent to Chiropractic Care. I do not expect the chiropractor to be able to anticipate or explain **all** the risks and complications. I wish to rely on the chiropractor to exercise his/her judgement during the course of procedures which he/she feels at the time, based upon the information known, is in my best interests.

I understand that the intent of chiropractic care is to assist me in achieving my fullest potential. I also understand that maintenance or wellness care does not rely on the presence of symptoms for its application and monitoring and I have, to the best of my knowledge, provided, the chiropractor with a complete and accurate health history. I have read the above consent. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic examinations, adjustments and other chiropractic procedures wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Signature of Patient: _____ Print Patients name here: _____
(or Parent/Guardian if under 18)

Parent/Guardian's name: _____ Date: _____

Chiropractor's Signature: _____ Date: _____