CHIROPRACTIC PATIENT

INTAKE & HISTORY

PATIENT INFORMATION

DATE____

FULL NAME____

☐ MALE ☐ FEMALE DOB_________________

HOME ADDRESS____

CONTACT TELEPHONE___________________________________

EMAIL ADDRESS_______________________________________

PRIVATE HEALTH FUND__________________________________

How many children do you have? ☐

OCCUPATION____

IN CASE OF EMERGENCY CONTACT

NAME____

RELATIONSHIP TO YOU__________________________________

TELEPHONE____

First visit to a Chiropractor? ☐ YES ☐ NO

PREVIOUS PRACTICE____________________________________

HOW DID YOU HEAR ABOUT US?

☐ Facebook ☐ Friend ☐ Google ☐ Walk In

Other ____

HOW CAN WE HELP YOU?

What brings you in today? ☐ SPINAL CHECK-UP ☐ SPECIFIC PROBLEM

If you are already experiencing a symptom, what is it? ________________________________

When did it start/what caused it? ____

How bad is it? How intense are your symptoms? (0 = no symptom, 10 = intense) ☐

Please circle areas (on diagram) where you have pain or other symptoms:

What does it feel like?

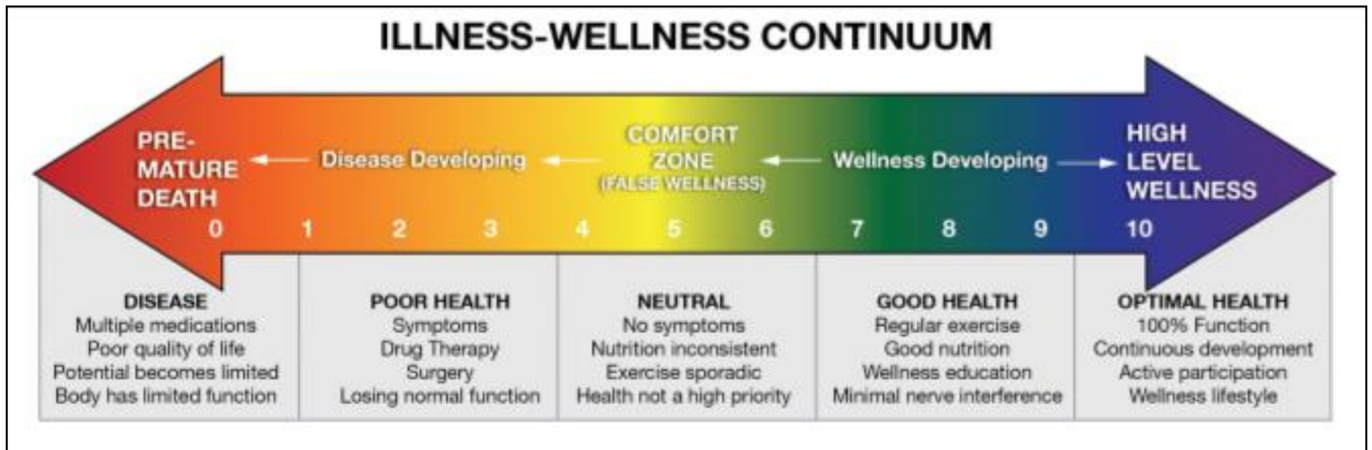
☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing
☐ Cramping ☐ Swelling
☐ Nagging Other ______________________

IMPACT OF YOUR SYMPTOMS

How is your symptom/condition interfering with your life?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other________	☐	☐	☐	☐

PATIENT WELLNESS ASSESSMENT					
Please check each answer appropriately based on the last week.					
	NEVER	RARELY	OCCASIONALLY	REGULARLY	CONSTANTLY
Presence of physical pain (neck/back ache, sore arms/legs)	☐	☐	☐	☐	☐
Feeling of tension/stiffness/lack of flexibility in your spine	☐	☐	☐	☐	☐
Feeling unable to perform everyday household activities	☐	☐	☐	☐	☐
Feeling of poor posture (sore neck/round shoulders)	☐	☐	☐	☐	☐
Incidence of physical restriction	☐	☐	☐	☐	☐
Incidence of muscle strain, spasm or cramping	☐	☐	☐	☐	☐
Incidence of pain with activity (catching restriction)	☐	☐	☐	☐	☐
Incidence of discomfort following activity (soreness)	☐	☐	☐	☐	☐
Incidence of dizziness or light headedness	☐	☐	☐	☐	☐
Incidence of accident/near accidents/falling/tripping	☐	☐	☐	☐	☐



On the arrow diagram above:

A. What number do you think represents your health today? ____

B. In what direction is your health currently headed? ____

What are your health goals?

SHORT TERM (3months) Pain Sleep Flexibility Headaches Walking Running Strength Exercise Balance

LONG TERM (6 months) Posture Mobility Mood Energy Digestion Immunity Breathing Other ______________

HEALTH & ILLNESS HISTORY

Please check any condition that you have or have had.

☐ AIDS/HIV	☐ Depression	☐ Knee/Ankle/Foot issues	☐ Thyroid issues
☐ Alcoholism	☐ Diabetes	☐ Multiple sclerosis	☐ TMJ issues
☐ Anxiety	☐ Digestive issues	☐ Neck pain	☐ Urinary issues
☐ Arthritis	☐ Elbow/Wrist/Hand issues	☐ Reproductive issues	☐ Osteoporosis
☐ Asthma/Allergies	☐ Headaches/Migraines	☐ Ringing in ears	Other
☐ Back pain	☐ Heart disease	☐ Scoliosis	______________________
☐ Cardiovascular issues	☐ Hepatitis	☐ Shoulder issues	______________________
☐ Cancer	☐ Hip issues	☐ Stroke	______________________

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Allergies *(list)*	Medications *(list)*	Supplements *(list)*
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Katherine Sports &
FAMILY CHIROPRACTIC

CHIROPRATIC CARE FOR THE WHOLE FAMILY

We are a family practice, meaning we are registered, trained and qualified to provide chiropractic services to people of all ages from babies, teenagers, adults and the elderly. If you suspect your child or loved one may have one of the below conditions, please check the box and talk to one of our doctors or staff about having them looked after.

☐ ADHD	☐ Allergies	☐ Asthma	☐ Bed wetting	☐ Birth trauma	☐ Breast feeding
☐ Clicky hips	☐ Colic	☐ Constipation	☐ Crawling	☐ Developmental	☐ Flat footed
☐ Flat-head	☐ Indigestion	☐ Irritability	☐ Knock knees	☐ Poor posture	☐ Reflux
☐ Restlessness	☐ Scoliosis	☐ Sleeping issues	☐ Tummy time	☐ Wry-neck	

INFORMED CONSENT TO CHIRPRACTIC CARE

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilisation, are required to inform patients that there are or may be some risks associated with such treatment. In particular: -

a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.

b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilisation. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.

c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and /or mobilisation, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall wellbeing. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular, as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilisation to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). This consent applies to all my present and future treatments at this clinic.

24 Hour Cancellation policy: If you miss your appointment or cancel within 24hrs, you will be charged a fee for that appointment. By giving last minutes notice, you prevent someone else booking into that time slot. Thank you for your understanding.

PATIENT NAME: ______________________________ **PATIENT SIGNATURE:** ___________________________ **DATE:** _____________

CHIROPRACTOR NAME: _________________________ **CHIROPRACTOR SIGNATURE:** _____________________ **DATE:** _____________