Name:_____ D.O.B. _____ I.D. _____ Date: _____

Welcome to Connective Chiropractic, Dr Bill Logan and Dr Brandon Doyle.

Please take the time to complete all three of our initial consultation information forms.

First Name Surname

Mrs/Miss/Dr/Other What do you like to be called?

Address Suburb Postcode

Email (Required for statements/communications)

Home/Work Phone Mobile

Date of Birth Marital Status ☐ Married ☐ Single ☐ Partner ☐ Widowed

Partner's Name Children's names and ages

(cont/d)

Occupation Employer

Do you have a Private Health Fund with Chiropractic Cover? ☐Yes ☐No If Yes, Name

Who may we thank for referring you to our office?

When did you last see a chiropractor? What was the date of your last spinal x-rays?

Your GP Address

List any prescribed medications/drugs you are currently taking

(cont/d)

For females only – Is there a chance you could be pregnant? ☐ Yes ☐No

Are you consulting our office for a ☐Wellness Evaluation ☐Specific Heath/Spinal Concern

Please describe your health/spine concerns below:

1. for how long?

2. for how long?

3. for how long?

Is your primary objective ☐Short term relief? ☐To correct the cause of the symptoms?

Please tick any of the following symptoms you have experiences at any time in the past 12 months

☐Headache	☐Breathing problems	☐Nervousness/Depression
☐Neck pain/stiffness	☐Asthma	☐Allergies/Hay fever
☐Dizziness	☐Digestive problems	☐Recurrent colds or flu
☐Ringing in the ears	☐Reproductive Problems	☐Weight problems
☐Numbness/Tingling in hands	☐Low Back Pain	☐Tension and irritability
☐Shoulder tension/pain	☐Hip Pain (Left or Right)	☐Menstrual problems
☐Pain between the shoulders	☐Numbness/Tingling in Legs	☐Difficulty sleeping

Name:_____ D.O.B. _____ I.D. _____ Date: _____

IT IS A LEGAL AND SAFETY REQUIREMENT THAT YOU ANSWER ALL OF THE FOLLOWING QUESTIONS

It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. Have you experienced any of the following in the past 30 - 90 days?

- Unsteadiness of your feet or severe dizziness ☐ Yes ☐ No
- Difficulty talking or swallowing ☐ Yes ☐ No
- Unrelenting nausea or vomiting ☐ Yes ☐ No
- Severe headaches or neck pain unlike ever before ☐ Yes ☐ No
- Ringing in the ears or recent visual changes ☐ Yes ☐ No

Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine. Have you experienced any of the following in the past 30 - 90 days?

- Loss of bowel or bladder control ☐ Yes ☐ No
- Loss of leg muscle size or numbness in the legs ☐ Yes ☐ No
- Difficulty standing or progressive weakness in the legs ☐ Yes ☐ No
- Shooting or sharp pain in the low back or legs when coughing or sneezing ☐ Yes ☐ No

General Health History

- Any history of bone thinning disease such as osteoporosis or long term corticosteroids? ☐ Yes ☐ No
- Do you have ANY diagnosed health issues? (e.g. diabetes, asthma, cancer, high blood pressure etc) ☐ Yes ☐ No
- Any recent large loss of weight? ☐ Yes ☐ No
- Have you any implants, surgical clips or foreign bodies such as pace-makers? ☐ Yes ☐ No
- Do you give permission for us to share your case information with your immediate family? ☐ Yes ☐ No

Please note that we do not accept any third party cases such as

Workcover or Motor Vehicle Accident Claims.

Patient Name **Date**

Patient Signature

Name:_____ D.O.B. _____ I.D. _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Scope of Care: Chiropractic care is focussed on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercises, traction devices, shoe lifts or specifically prescribed orthotic devices to help the spinal corrections.

Medication: Many patients experience great health improvements beyond spinal improvement and it is common for patients to report changes in medical health conditions,. However, changes in medications or management of medical conditions need to be done by your General Practitioner or specialist. Chiropractors cannot advise you as to your medical needs.

Alternatives to Chiropractic Care: If a patient does not want to improve spinal alignment or function then the alternative is pain relief care with other health professionals or care designed to stabilise the spine such as core exercise.

Risks of Not Undergoing care: Spinal problems may get worse if untreated and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and affect general health.

RISKS TO PATIENTS

All types of care and examinations have associated risks and it is important that a patient accepts these before undergoing examination and any care including adjustments, exercise and/or traction. Adjustments require forces to move spinal bones and as such put stresses on blood vessels, bones, discs, nerves and soft tissues. The below are some of the more serious and more common risks, but it is not an exhaustive list.

A) **RARE BUT SERIOUS RISKS:** Damage to blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury.
B) **MORE COMMON BUT LESS SERIOUS RISKS:** Sprains, strains, rib fractures, bruising inflammation and soreness.

Consent for X-Rays: X-rays are taken when indicated to assess spinal biomechanics and the integrity of osseous and soft tissue structures.

For females only: Pregnancy Release: X-rays can be hazardous to an unborn child. In signing below I consent to x-ray evaluation and certify that to the best of my knowledge I am not pregnant.

If you have further questions regarding risks of examination or care then please ask the Chiropractor before signing below. Your examination results and recommendations for any care and alternatives to care will be thoroughly discussed in private with the Chiropractor and the assistant.

In signing below you acknowledge that you have been given opportunity to ask further questions about the spinal examination and spinal x-rays.

I, the undersigned, consent to examination, any necessary x-rays and any agreed care.

NAME _____ **DATE** _____

SIGNATURE _____

CHIROPRACTOR'S SIGNATURE _____