KING CHIROPRACTIC

INTAKE QUESTIONNAIRE

66 Frankel Street, Carey Park WA 6230
P.O Box 6488, South-Bunbury WA 6230

WELCOME to our practice.

Please answer these questions as completely as possible and return to the receptionist.

PERSONAL INFORMATION:

First Name: **Last Name:**

DOB: **Gender:** **Occupation:**

Address:

Suburb: **Post Code:**

Home Phone: **Mobile:**

Email:

Who is your GP?

How did you find out about us? *Google / Facebook / Instagram / Youtube / Street Sign* or *Friend* **(Please name so we can thank them?) :** **Tel:**

COMPLAINT HISTORY:

Where is your complaint? (Please circle complaint and include any relevant detail)

Headache	Neck Pain	Mid-Back Pain	Low-Back Pain	Feet / Hands	Abdomen

Details:

How did your complaint start (mechanism): *Traumatic / Insidious*

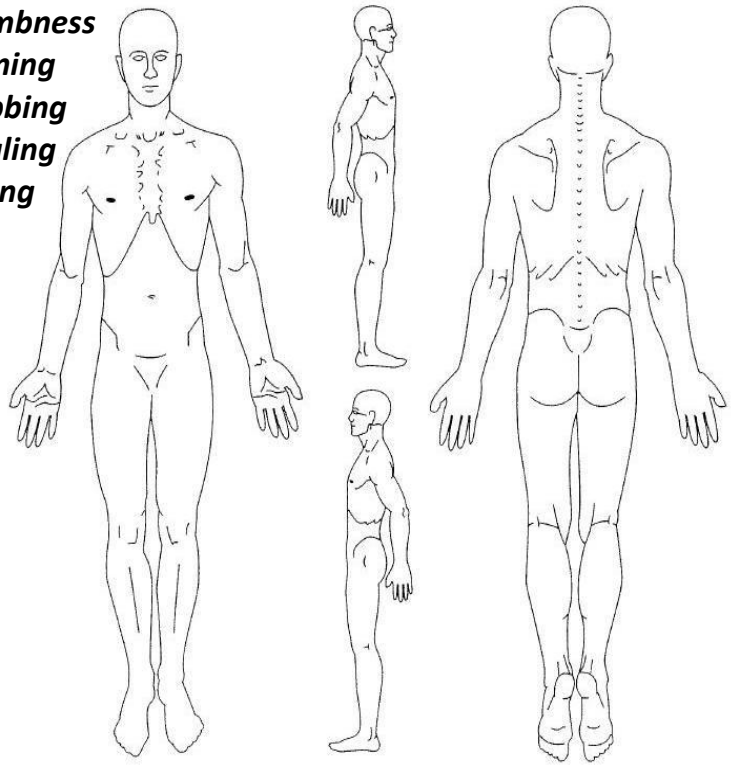
When did it start: _____ **Have you had this before?** *Yes / No*

Have you had previous treatment for this complaint? *Yes / No*

If so please state what type of therapy: _____

On the Diagram below please indicate where you are experiencing the following symptoms:

N = Numbness
B = Burning
S = Stabbing
T = Tingling
A= Aching



On the scale below please circle the severity of the pain now

No pain **Moderate pain** **Worst pain ever had**

0	1	2	3	4	5	6	7	8	9	10

HEALTH HISTORY:

Have you experienced any of the following over the last 3 months?

□ Visual disturbances
□ Difficulty speaking
□ Difficulty breathing
□ Dizziness
□ Unsteadiness
□ Numbness or tingling
□ Weight loss
□ Fevers or chills
□ Shaking or night pain
□ Difficulty walking
□ Loss of consciousness

Have you or your family ever had any of the following?
Please indicate relationship to yourself (mother, cousin, father etc.)

□ Arthritis
□ Parkinson's disease
□ Headache or migraine
□ Asthma
□ Multiple sclerosis
□ High blood pressure
□ Scoliosis
□ Dementia
□ Allergies
□ Cancer
□ Diabetes
□ Stroke
□ Heart disease
□ Osteoporosis
□ Eye problems
□ Alcoholism
□ Stress
□ Depression

- Does your work typically involve any of the following?

  □ bending □ lifting □ vibration

- Previous occupations: _____
- Recreational activities, hobbies and sport: _____

Have you had any of the following: *Pease include Year of Incident or your approximate age at the time of incident, the location of injury/problem and if relevant where and how it happened.*

- **Broken bones** No / Yes - details: _____
  _____
- **Hospitalisations:** No / Yes - details: _____
  _____
- **Surgeries:** No / Yes - details: _____
  _____
- **Serious Illnesses or Cancer:** No / Yes - details: _____
  _____
- **Work Injuries:** No / Yes - details: _____
  _____
- **Medications:** No / Yes - details: _____
  _____
- **Supplements:** No / Yes - details: _____
- **Do you smoke:** No / Yes - details: _____
- **Do you drink alcohol:** No / Yes - details: _____

Typical Diet: _____

Typical sleep: _____

Typical Exercise: _____

TEL: 08 9792 4476 Email: admin@kingchiropractic.com.au

KINGCHIROPRACTIC

INFORMED CONSENT TO UNDERGO CHIROPRACTIC TREATMENT

Chiropractic is a safe, effective and appropriate way to care for many skeletal complaints. Chiropractic is recognized as one of the safest types of health care in the world. Numerous studies, including those funded by governments, universities and non-profit research institutions, have proven it to be a highly successful system of care for neuromusculoskeletal conditions. Chiropractic is safer, in fact, than most medical procedures used to treat the same conditions.

Understanding the risks of chiropractic care:
The most common adverse effects of chiropractic is minor musculoskeletal pain, stiffness and headache which can occur in over 20 percent of patients after their first treatment. The most serious risk identified with chiropractic adjustments is a condition known as vertebrobasilar stroke (VBS), which occurs when sudden head movements disrupt the blood flow in the vertebral artery, which may then possibly lead to stroke. The risk of this complication arising from upper cervical (or neck) manipulation by a chiropractor is extremely remote.

According to the review article "What are the risks of manual treatment of the spine" written in 2017 as a review and summary of over 250 chiropractic risk studies,
-only 1 out of every 2 million chiropractic neck adjustments may cause stroke symptoms. Others have calculated the risk to be as low as 1 in 3.8 million treatments.

To put it another way, you are five times more likely to get hit by lightning than to suffer VBS at the hands of a chiropractor. Other lessor risks according to the Halderman & Dvorak studies, include sprain or other injury to a ligament or disc in the neck (less than 1 in 139,000) and lower back (1 in 62,000).
In comparison to allopathic medicine, which uses drugs and surgery as an integral part of treatment, chiropractic presents far less risk.

But with all forms of treatment, whether allopathic or alternative, any risks, however slight, should not be ignored. While the methods used by chiropractors have proven to be safe in almost all cases, it is a constant concern for chiropractors to evaluate their patients to determine if treatment will cause an adverse reaction.

Most chiropractic patients receive cervical manipulation as part of their individual chiropractic care. It may be performed as part of your care for total spinal health and wellness, or for specific problems such as muscle tension and stiffness, headache or injury.

Consent to undergo chiropractic care:
I hereby acknowledge and understand the above risks and consent to undergo chiropractic manipulative care (in the case of a minor, this must be signed by a parent or legal guardian).

Full Name: _____

Signature: _____ Chiropractors' Signature: _____ Date: / / 20

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KING CHIROPRACTIC

We Care About Your Privacy

To ensure your privacy, this Practice adheres strictly to the National Privacy Principles of the Commonwealth of Australia privacy legislation.

Your health information is collected by us only with your consent and as necessary for the proper and effective treatment of your condition.

Health information about you will not be released to any other party including other treating health providers without your consent. You may review your health information with your treating provider at any time and are entitled to access your health records for this purpose. If you have any concerns about the confidentiality of your health information, please feel welcome to discuss these with your chiropractor.

Please let your healthcare practitioner know if you have any questions or wish to add any more information.

Authority to Release Information

The information that I provided is complete and accurate to the best of my knowledge and I, (please print name) _____hereby authorise the release of records which make up my patient file held by my Health Professional(s) for purposes of optimal treatment at King Chiropractic.

_____
SIGNATURE

_____
DATE

Legal guardian's name: _____ **(if applicable)**

Legal guardian's signature: _____ **(if applicable)**

Copies of the records are to be forwarded to the above address please.