natural health chiropractic

New Patient Form

Welcome to Natural Health Chiropractic. Please take the next few minutes to complete this form to provide important information so that we can help you get the most from your chiropractic care.

First name: _____ Surname:_____

Address: _____

Suburb:_____ Postcode:_____ State:_____

Occupation:_____ Date of Birth:_____

Phone:_____ Mobile:_____ Email:_____

Spouse's (or other relative/friend) Name:_____Mobile:_____

Relationship: _____

How many hours per day at work/daily routine do you spend sitting?_____standing? _____

Who can we thank for referring you/ where did you find out about us?_____

Do you agree to an x-ray examination of your spine if required? ☐ Yes ☐ No

Do you have Private Health Insurance? ☐ Yes - (please list your provider below) ☐ No

_____

Why have you come to see us?

If you have no symptoms or complaints and are here for wellness services, please skip to **"Vital Health Profile"**.

Please list your health concerns according to their severity	Rate the severity 1 = mild 10= excruciating	When did this episode start?	If you've had this condition before - when was it?	Did the problem begin with an injury?	% of time pain is present?
1					
2					
3					
4					

Vital Health Profile:

Please mark the conditions you have experienced in the past with a ✖ or ones you experience currently with a ✓

☐ Neck pain	☐ Numbness	☐ Sinus problems	☐ Dizziness
☐ Allergies	☐ Anxiety	☐ Ringing in the ears	☐ Thyroid problems
☐ Depression	☐ Mid back pain	☐ Breathing problems	☐ Epilepsy
☐ Trouble sleeping	☐ Lower back pain	☐ Heart attack	☐ Asthma
☐ High blood pressure	☐ Chest pains	☐ Digestive problems	☐ Heart disease
☐ Ear infections	☐ Cancer	☐ Diabetes	☐ Recurrent colds/flu
☐ Eczema	☐ Incontinence	☐ Multiple Sclerosis	☐ Arthritis
☐ Headaches/Migraines	☐ Low energy	☐ Learning difficulties	☐ Stroke
		☐ Visual problems	☐ Urinary tract infection

Ladies:

☐ Menstrual problems	☐ Menopausal problems	☐ Infertility	☐ Currently pregnant (weeks): _____

Men:

☐ Prostate problems	☐ Impotence	☐ Infertility

All Patients:

How would you rate your current level of health? (very poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

What importance do you place on your health and wellbeing? (none) 1 2 3 4 5 6 7 8 9 10 (most)

What is your desired outcome from your chiropractic/massage care?

☐ Wellness care and optimal health ☐ Relief care only ☐ Spinal check-up ☐ Other (please specify) _____

If we could help with other areas of your life, which of these would they be?

☐ Energy levels	☐ Hormone balance	☐ Digestion	☐ Breathing
☐ Coordination	☐ Happier moods	☐ Quality of life	☐ Immunity
☐ Exercise recovery	☐ Bowel function	☐ Quality of sleep	☐ Weight control
☐ Cope with stress	☐ Flexibility	☐ Bladder function	☐ Muscle tension/strength

Are you interested in learning how nutrition may affect your problem, as well as your overall wellbeing?	☐ Yes ☐ No
Would you make dietary changes or take supplements if recommended?	☐ Yes ☐ No
If specific, tailored exercises/stretches could assist you in recovery, are you likely to do them to receive maximum benefit?	☐ Yes ☐ No

Is there anything else you feel we need to know to help us understand how you're feeling?

Safety

There are just a few last questions we need to ask as we can sometimes be concerned that our patients may have symptoms indicating problematic blood vessels in your neck, or a damaged disc in your lower spine.

Have you recently experienced any of the following?

Unsteadiness on your feet or severe dizziness	☐ Yes ☐ No
Difficulty talking or swallowing	☐ Yes ☐ No
Unrelenting nausea or vomiting	☐ Yes ☐ No
Sever headaches or neck pain unlike ever before	☐ Yes ☐ No
Ringing in the ears or recent visual changes	☐ Yes ☐ No
Loss of bowel or bladder control	☐ Yes ☐ No
Loss of muscle size or numbness in legs	☐ Yes ☐ No
Difficulty standing or progressive weakness in legs	☐ Yes ☐ No
Shooting or sharp pain in the lower back or legs when coughing or sneezing	☐ Yes ☐ No

Thank you for your time to assist us with assessing your case. Your health and recovery are extremely important to us.

I have read and understood the need for my spouse to be in attendance at my second visit and the above information is true and correct to the best of my knowledge.

Signed:_____Date:_____

CONSENT TO CHIROPRACTIC CARE AND PRIVACY OF YOUR PERSONAL RECORDS

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must be aware that there are risks associated with health care procedures.

Please read the following carefully:

1. I acknowledge that I have been informed by a practitioner and/or staff at Natural Health Chiropractic of the rare risks associated with the proposed care which include, although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes and an exacerbation and/or aggravation of my underlying condition.

2. I have had the opportunity to discuss the proposed care with Kelly Wignell or Nick Wignell. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

4. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

5. I herby acknowledge my consent to the performance of the proposed chiropractic care by Kelly Wignell, Nick Wignell, and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time, in writing, should I decide to discontinue care at Natural Health Chiropractic.

6. Should my x-rays require further assessment, I give permission the Natural Health Chiropractic for my details, and/or x-ray films, to be viewed by outside radiology facilities for generating reports.

7. I understand that Natural Health Chiropractic collects information to assist in providing me with their services. This information is kept private, secure and confidential and may be used by this centre to contact me in regards to services or promotions being held. I hereby give consent to my information to be used in this way.

……..... Date:…….....
Patient's Signature (Parent or Guardian to sign if patient is under 18)

……..... …….....
Patient's Name **(Printed)** **Witnessed**