Andrew Vincent Chiropractic

Confidential New Patient Questionnaire

Personal Details

Title: Mr Mrs Ms Dr Mast Miss	Name:	Date:
Address:		
Suburb/Town:		Postcode:
DOB:	E-mail:	
Home Ph:	Mobile:	Work Ph:
Occupation & Employer:		
Emergency Contact:		Phone:

Andrew Vincent Chiropractic recognises the importance of protecting your privacy and abides by the Australian Privacy Principles contained in the (amended version: March 2014) Privacy Act 1988. The information that you give us will only be used to contact you regarding your health needs and dealings with us.

I would like an appointment reminder: SMS ☐ Email ☐ No thanks ☐

I am aware of and have read the attached privacy statement **Signed** _____

Do you have a: Student / Pensioner card? ☐ DVA file number? _____

CDM / Medicare Referral? ☐ Workcover claim number? _____

How were you referred to our clinic?

Friend/Family member ☐ Name: _____

Other Health Professional/Chiropractor ☐ Name: _____

Internet: Google ☐ Social Media ☐

AV Website ☐ Other ☐

Private Health Insurance ☐ _____

Promotion/Voucher ☐

Walked Past ☐

Other ☐ _____

Chiropractic History

Have you ever had Chiropractic care before? Yes ☐ No ☐

If so, when was your last visit? _____

Name of Chiropractor: _____ Suburb/Town: _____

Were X-rays taken? Yes ☐ No ☐

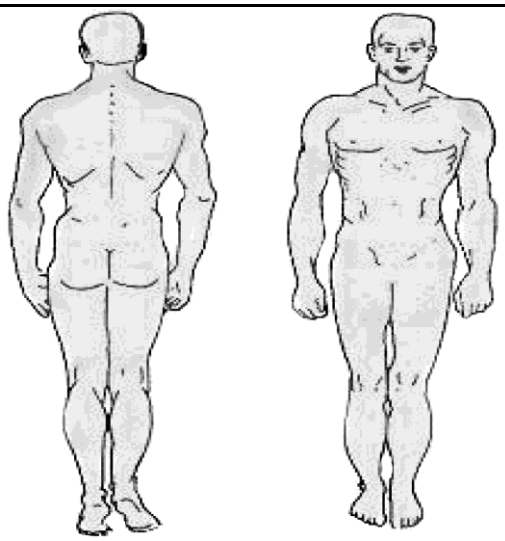
How would you rate your results? Excellent ☐ Good ☐ Poor ☐

Current Major Complaint

Describe your current condition: _____

_____

Please indicate the area (s) of discomfort on the diagram (on right):



Please indicate the severity of discomfort you are experiencing right now:

1	2	3	4	5	6	7	8	9	10
No pain			Discomfort		Very sore			Extreme pain	

Does your condition interfere with: Work ☐ Sleep ☐ Routine ☐

What makes your symptoms better? _____

What makes your symptoms worse? _____

When did your symptoms start? _____

Are they getting worse? Yes ☐ No ☐ Has this occurred before? Yes ☐ No ☐

If so, when did it occur? _____ How often? _____

Do you know what caused it? _____

Have you received any treatment for this condition? If so, please list: _____

Was it effective? Yes ☐ No ☐

General Health

A poorly functioning spine and nervous system can affect the way your entire body functions. Are you experiencing any other health problems, such as:

Please circle and write 'O' - for occasionally or 'F' - for frequently.

Headaches/Migraines	Asthma/Problems breathing	Muscle weakness
Double/Blurred vision	Cold/Painful Extremities	Fever/Nausea
Indigestion/Heartburn	Dizziness/Loss of balance	Painful cough/sneeze
Tingling/Numbness	Constipation/Diarrhoea	Ringing in ears

Please list any other health concerns: _____

Are you taking any medication? If so, list: _____

What lifestyle activities have you had to give up due to your current health condition? _____

_____

What are your health and lifestyle goals for the future?

3mth _____

On-going _____

Thank you for taking the time to complete this form.

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Informed Consent to Chiropractic Care

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives (A Risk Assessment of Cervical Manipulation. (1995). JMPT.) (The Manga Report. (1993). Ontario Ministry of Health.)

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 2.15 million). Other very slight risks include (but are not limited to) strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) [Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed.]

If you have any questions related to the treatment that you are about to receive, please speak to your Chiropractor.

Please do not sign until you have spoken to your Chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the Chiropractor and give my consent to treatment. I understand that results are not guaranteed and that the Chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.

I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and I have been given sufficient time to make a decision giving consent for the care to proceed.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment, by Dr. Andrew Vincent *B.App.Sc (Chiropractic)* , Dr. Mark Whitfield *B.Sc.M Chiropractic,* Dr. Jacinth Tan *B.App.Sc (Chiropractic) M.Clin.Chiropractic,* Dr. Matthew Platz *B.App.Sc (Medical Imaging) M.Chiropractic* and/or anyone working in this clinic authorised by Dr. Andrew Vincent *B.App.Sc (Chiropractic).* I understand that I can withdraw my consent at any time.

Date: _____

Patient's Signature: _____

Print Name: _____

Parent/Guardian Signature:
(if patient is under 18yrs) _____

If Female, could you be pregnant? **Yes** ☐ **No** ☐

Chiropractor's Signature: _____