Salus Chiropractic Clinic

Date:

INITIAL CONSULTATION FORM

Confidential

PATIENT INFORMATION

Patient's Given name: Middle: Surname:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar/ Defacto / Div / Sep / Wid
Country of Birth:	D.O.B: / /		Age:	Male: ❑ Female: ❑
Street address:		Suburb:		Post Code:
State:	Phone (H): ( )	Phone (W) ( )		Mobile Number:
Occupation:	Email Address:			Do you wish to be sent reminders for you appointments? ❑ Yes (Via SMS/Email) ❑ No

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Health Insurance Provider	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other:

Other family members seen here:

PRESENTING COMPLAINT

Please describe your present problem:

When did this problem start?

What were you doing?

What makes it better?	What makes it worse?

Describe the feeling or sensation you have with this problem (Please tick/circle)

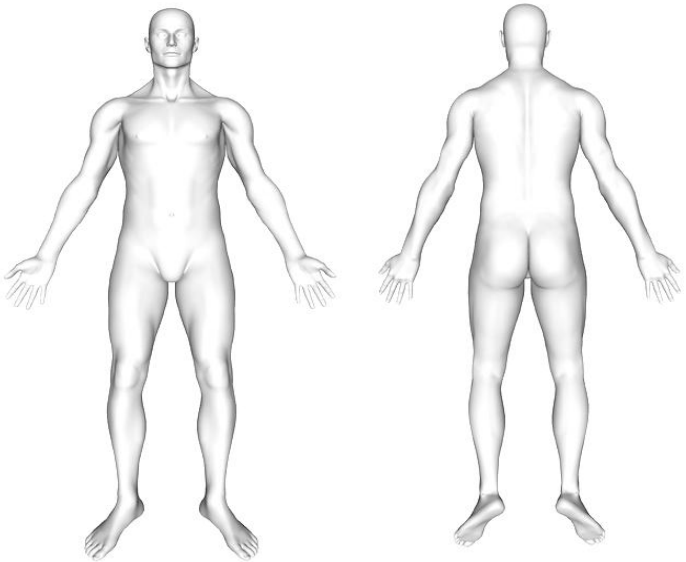
❑ Health Check (No Problems)	❑ Sharp Pain	❑ Dull Pain	❑ Ache	❑ Weakness	❑ Throbbing
	❑ Numb	❑ Shooting	❑ Gripping	❑ Burning	❑ Tingling (Pins & Needles)

Please mark on the diagram where you have pain and/or other symptoms:

Please use symbols to indicate sensation:
(x) for pain
(0) for numbness/pins & needles

Are your symptoms:
❑ Increasing
❑ Decreasing
❑ Not changing

How frequent is the pain:
❑ Constant
❑ Intermittent
❑ Occasional
❑ Rarely



Note:

Please include any other associated symptoms which you would like to indicate

Other spinal problems:

Other peripheral problems:

VAS: On a scale of zero (0) to ten (10) how you rate your current pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

My symptoms are affecting (please tick / circle): ❑ General Activities ❑ Leisure ❑ Sleep ❑ Work ❑ Other (please describe) :

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1 Dragon Street HILLCREST SA 5086

MEDICAL & FAMILY INFORMATION

(If unsure or not known please leave blank)

Previous Chiropractor / Acupuncturist:	Date of last visit:
Current Medical Practitioner (GP) :	Practice / Clinic:
Hospitalisation &/or Surgeries:	
Accidents & Trauma:	

Current Medications & Supplements:	Family History:	
	❑ Cancer ❑ High Blood Pressure ❑ Diabetes ❑ Arthritis	❑ Stroke ❑ Heart Attack ❑ Seizures/Convulsions ❑ Mental Illness
Do you smoke: ❑ No ❑ Yes How much:	Do you drink alcohol: ❑ No ❑ Yes How much:	

What are your stress levels like (1 minimal, 10 major/burnout): Work ( ) Home Life ( ) Financial ( ) Health ( ) Other ( )

SYSTEMS REVIEW

Do you now, or have ever had, any of the following (please tick)

General / Constitutional
- ❑ Unexplained weight loss
- ❑ Excessive fatigue
- ❑ Prolonged fever / chills
- ❑ night sweats
- ❑ do you have trouble sleeping
- ❑ allergies
- ❑ other

Head / Eyes / Ears / Nose / Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Wear glasses or contact lens
- ❑ Chronic nasal discharge / sneezing
- ❑ Impaired hearing
- ❑ Recent eye examination
- ❑ other

Gastrointestinal
- ❑ abdominal pain
- ❑ Vomiting
- ❑ loss of appetite
- ❑ change of bowel habits
- ❑ blood in the stools
- ❑ haemorrhoids or rectal disease
- ❑ other

Respiratory
- ❑ chronic cough
- ❑ Asthma or wheezing
- ❑ shortness of breath
- ❑ shortness of breath at night
- ❑ other

Cardiovascular
- ❑ Any heart trouble
- ❑ Pain or pressure in chest / Angina
- ❑ Rheumatic Fever
- ❑ Palpitation or pounding heart
- ❑ Swelling of ankles
- ❑ High blood pressure
- ❑ other

Haematological / Lymph
- ❑ anaemia
- ❑ excessive bleeding / bruising
- ❑ a transfusion
- ❑ any swelling of lymph glands
- ❑ other

Neurological
- ❑ Memory loss
- ❑ fainting, dizziness, convulsions
- ❑ slurred speech
- ❑ other

Skin / Breast
- ❑ change or new growth in mole
- ❑ breast lump
- ❑ breast nipple discharge
- ❑ other

Genitourinary
- ❑ frequent urination at night
- ❑ frequent or painful urination
- ❑ difficulty holding urine
- ❑ difficulty stopping / starting urine flow
- ❑ urinary tract infection
- ❑ other

Endocrine
- ❑ cold or heat intolerance
- ❑ excessive thirst or hunger
- ❑ trouble losing weight
- ❑ other

Musculoskeletal
- ❑ pain in the joints / arthritis
- ❑ red inflamed joints
- ❑ chronic back pain or injury
- ❑ other

Female
- ❑ mid-cycle bleeding
- ❑ unusual vaginal discharge
- ❑ painful periods
- ❑ inconsistent menstrual cycles
- ❑ premenstrual pain
- ❑ pain with intercourse
- ❑ have you ever been pregnant
- ❑ other

Male
- ❑ sore or discharge from penis
- ❑ lump or pain on testicle
- ❑ problems with sexual function
- ❑ other

Psychological / Emotional
- ❑ high stress levels
- ❑ are you often depressed
- ❑ are you often anxious or nervous
- ❑ ever had loss of memory
- ❑ other

Signed: **Date:**

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INFORMED CONSENT TO CHIROPRACTIC CARE

Patient Information

Changes to the law now require all healthcare practitioners to warn patients of material risks. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** eg between 1 in 2 million to 1 in 5.85 million - Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (**current statistics** eg less than 1 in 139,000) and the low back (**current statistics** eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible. While this has never occurred in this environment, we are still required to warn. If any adjustments are required, you will be tested before hand as is our standard practice.

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully:-

1. I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

……..……
……..……
Please insert any details you wish to discuss

3. I have had the opportunity to discuss the proposed care with my chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

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

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

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by my chiropractor and/or any other chiropractor working in this practice. I understand that I can withdraw consent at any time.

7. **Express Verbal Consent (EVC)** will be continually updated together your chiropractor to maintain informed consent and give you opportunities to discuss or raise any concerns with treatment or progress.

……
Patient's Name (printed)

……
Patient's Signature

……
(Parent or Guardian to also sign if patient is u/16)

……
Chiropractor's Signature

Dated: ……

Consent Form v1.3 2010
Velo Health Pty Ltd ©

INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby request and consent to the performance of acupuncture treatments and other Chinese Medicine procedures on me (or the patient named below, for whom I am legally responsible) by the practitioner named below and/or other licensed practitioners who are contracted or employed by Velo Health Pty Ltd.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, Chinese or western herbal medicine, and nutritional counselling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur. Infection is another possible risk, although the practitioner below uses sterile disposable needles and maintains a clean and safe environment.

All procedures carried at the Salus Chiropractic Clinic follow the Guidelines of Safe and Hygienic Practice of Skin Penetration, prepared by The Environmental Surveillance Section, Strategic Planning and Population Health, Department of Health. And also the Chinese Medicine Registration Board of Victoria's *Infection Control Guidelines for Acupuncture* (June 2004)

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Express Verbal Consent (EVC) will be continually updated together your practitioner to maintain informed consent and give you opportunities to discuss or raise any concerns with treatment or progress.

……
Patient's Name (printed)

……
Patient's Signature

……
(Parent or Guardian to also sign if patient is u/16)

……
Practitioner's Signature

Dated: ……

SALUS CHIROPRACTIC CLINIC
1 DRAGON STREET HILLCREST
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