Welcome to

Institute of
Sports and Spines
820 Old Cleveland Road, Carina, 4152
Web: instituteofsportsandspines.com.au
Phone: 07 3398 7022

New Patient Information Form

Title:________ Name:________________________ Middle Initial/s: ____ Surname: ____________________

Home Address: _______________________ Suburb: ____________________________ Postcode:_________

D.O.B. _____________ E-mail address: ____

Phone Numbers Home: __________________ Work: __________________ Mob:_______________

Private Health Fund: __________________ Memb No. ____________________ No. on Card ___________

Medical Practitioner's (GP) Name: ________________________________ Phone: ____________________

Next of Kin/Emergency Contact: _______________ Relationship: ______________ Ph: ________________

Name of person who referred you to us or how did you hear about us? ___________________________

What is your occupation or major daily activity? ____

Hobbies / Sports / Specific Health interests: ____

Do you exercise regularly? If so please give details? ____

I **would like to receive marketing emails from Institute of Sports and Spines** □ Yes □ No

REASON FOR VISIT: ____

Headaches □ Yes □ No Dizziness □ Yes □ No

Please indicate the approximate areas on the diagrams:

(Pain - XXXX) (Pins & Needles - \\\\\\\\\\) (Numbness - 000000)

(PLEASE CLICK IN THE BODY DIAGRAM AND USE SPACE AND ENTER KEYS) >>

R L L R

Please indicate the level of pain you are suffering.

1	2	3	4	5	6	7	8	9	10

How would you describe the pain/problem? ___________________________

When and how did the problem start? _______________________________

Does it re-occur? □ Yes □ No When and how often? _______________________________________

Is the pain worse: □ Morning □ Evening □ During the night Does the pain wake you at night? □ Yes □ No

Does anything aggravate the pain? □ Lying □ Standing □ Sitting □ Movement □ Other _____________

Does anything relieve the condition? □ Yes □ No If yes please explain ______________________

Have you taken any form of pain killer prior to this treatment? _______________________________

What treatment have you had for this condition? ____

What goals do you hope to achieve with treatment? _______________________________________

Are you good at maintaining exercises and routines or do you need support? ____________________

What activities cause you pain? What do you avoid because of the potential for pain or restriction? What would be good benchmarks to use to assess progress? ____

How many cigarettes per day do you smoke? ____ How many previously and when did you quit? _________

Recent change in? □ Weight □ Vision □ Hearing □ Taste □ Smell Please List: ____________________

Please complete page 2...

Have you had or do you have existing ailments (If so please give details):-

□ Fractures ______________________________

□ Dislocations ______________________________

□ Major Accident's ______________________________

□ Medical Tests / Blood tests ______________________________

□ Surgery ______________________________

□ X-rays ______________________________

□ Medication ______________________________

□ Illness ______________________________

□ Infection / fever ______________________________

□ Smoking ______________________________

□ Recent GP visit ______________________________

□ Other ______________________________

Have you previously, or do you currently experience any of the following conditions?

Are you pregnant	□	Allergies	□	Stroke / DVT	□	Blood/Heart Disorders	□
Migraines	□	Cancer	□	Epilepsy	□	Auto-Immune Disorder	□
Bowel/Bladder	□	Digestive	□	Insomnia	□	Sexual Dysfunction	□
Thyroid Disorders	□	Stress	□	Anxiety	□	Emotional Disorders	□

Please give details: ______________________________

Do you have a family history of □ Stroke □ Heart/ Blood disorders □ Cancer / Malignancy □ Diabetes □ Other

Please List ______________________________

<u>Consent To Treatment – Patient Information</u>

Changes to the law now require all practitioners to advise 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. Studies indicate approximate risk ranges from 1.3 in 100,000 or 0.0013 % (Rothwell 2001) to 1 in 5.85 million or 0.0000001 % (Neck manipulations. Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to inform. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strains/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 and Practice of Chiropractic, Haldeman. 2nd Ed.]

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

If you have any questions related to the treatment you are about to receive, please speak with the practitioner.
You can choose other alternatives to this treatment, which might include; chiropractic without manual adjustment, no treatment, medicine, physical medicine, chiropractic, physiotherapy, acupuncture, massage or other:______________________________

I have discussed the above information with the Practitioner and understand the risk. I give my consent to treatment, which
may include spinal adjustment. The information I have provided is correct and complete. In signing this document I agree to indemnify the Provider of this service and its employees, agents and representatives from claims made against them in the event that I react to the treatment provided.

We value your time and appreciate helping you with your Health care needs. Your appointment is important to us.
As missed appointments may inconvenience other patients, our clinic has employed a policy of charging a normal consultation fee for missed appointments and those appointments cancelled without 4 hours' notice. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

Print Full Name:______________________________ Patient's Signature(or Legal Guardian): ________________

Date: / / 20

Entering your name in the box above acknowledges that you have read the form and consent to assessment and treatment.