Port Lincoln Chiropractic Center

Confidential Patient History

The more I know about you, the more I can help.
Please answer all questions to the best of your ability and ask for help if you need it.
Of course, all information will be kept strictly confidential.

Section A

Name (*your official one*): _____

Preferred Name (*the one you like to be called by*):_____

Male / Female Date Of Birth / /

Mailing Address: _____

Email Address: _____

Phone: (H)_____ (W)_____ (Mob) _____

Occupation: _____

Do you have private health insurance which covers chiropractic? Yes / No

What do you do for fun?_____

Partner's Name: _____ Number of Kids: _____

Are you pregnant? Yes / No If so, how many weeks? ____

How did you find out about us? _____

Have you ever been to a chiropractor before? Yes / No How long ago? _____

If Yes, were you on Wellness/Maintenance Care? Yes/No

Have you had spinal X-rays or scans in the last 5 years? Yes / No

Specific health complaint you would like us to address {please describe location)

If you have an injury, how did this injury / complaint occur?

How long have you had this problem? Have you had a similar problem in the past?

What aggravates the problem? What relieves the problem?

Is the problem getting: Worse? Better? Comes and Goes? Stays the Same?

Does the problem interfere with:
Work Leisure /Sport /Daily Routine /Sleep /Your Relationship

Your Expectations

Relief of Symptoms
To improve the health of my spine and nervous system
To Maximize my health
To maximise the health of my Family and Community

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Section B

Do you know of any complications during or after your own birth (eg breech, forceps delivery, Caesarian, cord around neck)? _____
_____

Please list any major traumas/illnesses throughout your life eg. any surgery, cancer, stroke, major falls, car accidents, fractures, concussions:
_____
_____
_____

Are you currently taking any Medications? Yes / No
Details _____
_____

Do you currently suffer from: Dizziness, Chest pain, Unexplained weight loss, Excessive tiredness, Fever, Fits, Fainting, High blood pressure (*circle if Yes*)?

Do you smoke? Yes / No Average number per day ___

Do you drink alcohol?Yes / No Average number per week ___

How would you rate your diet? 1/10(terrible)--------10/10(excellent)

How would you rate the level of stress in your life? 0(none)--------10(help!!)

Do you get daily exercise other than your work? Yes / No

Do you have a regular sleep pattern? Yes / No
How many hours would you get per night, on average? ____

How would you rate your health generally? 1/10(terrible)-----10/10(excellent)

At what level would you prefer it to be? 1/10(terrible)------10/10(excellent)

What do you do regularly do to improve your health and your life?
_____
_____
_____

Signed _____ Date_____
(by parent/guardian if under 18 yrs)

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Privacy Policy

In accordance with the Privacy Act, your personal information is held in total confidence. However, your consent is necessary to allow me to exchange information with other chiropractors or health professionals when appropriate.

Consent For Care

Changes to the law now require all practitioners who adjust the spine to warn people of material risks. In extremely rare circumstances some adjustments of the neck may damage a blood vessel and give rise to stroke or stroke like symptoms. Current literature states this to be approximately 1 in 5.58 million (Haldeman, et al. Spine vol. 24-28 1999).

Whilst this has never occurred in this practice, I am still required to warn. If any adjustments are required you will be tested beforehand, as has always been my practice.

Other very slight risks include strain / injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000).

Please note that this consent does not waive your common law rights, rather it is merely for you to acknowledge that you have been informed of the known risks. If you have any questions related to the care you are about to receive or possible alternative approaches, please speak to the chiropractor.

I will inform Dr.Andy Hsu/ Dr. Ben Kalyvas of any concerns I have about the effect on my health these procedures may have.

_____ _____

(name: please print) (date)

_____

(patient signature/ or legal guardian)

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Terms Of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the methods that will be used to obtain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or symptoms.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter, non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of a health care provider who specialises in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE Objective** is to eliminate major interference to the expression of body's innate wisdom.

Our only method is specific adjusting to correct vertebral subluxation

I, _____ Have read and fully understand the above statements.
(Print Name)

I, therefore, accept chiropractic care on this basis

Signed _____ Date_____
by parent or guardian if person is under 18