Kingsford Chiropractic Clinic
Centre For Rehabilitation

WELCOME TO OUR PRACTICE

PERSONAL DETAILS

Date _____

MR / MRS / MS / MISS *(Please circle)*

FIRST NAME/S _____ SURNAME _____

DATE OF BIRTH _____ OCCUPATION _____

STREET ADDRESS _____

SUBURB _____ POSTCODE _____

CONTACT DETAILS

MOBILE _____ HOME _____ WORK _____

EMAIL _____

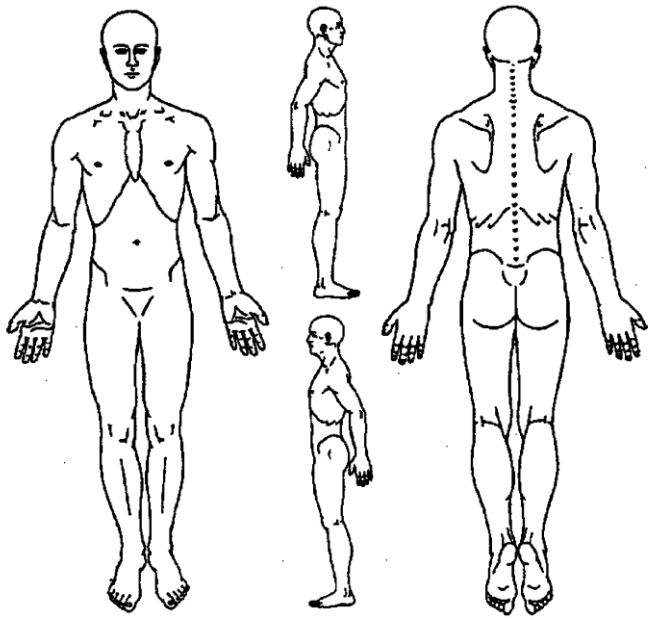
How did you hear about Kingsford Chiropractic Clinic? _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Number _____

HEALTH DETAILS

Please mark the area of injury or discomfort on the diagrams below



Major Complaint:

Please rate your pain/discomfort level *(Please circle)*
None
1
2
3
4
5
6
7
8
9
10
Severe

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Is this a Workers Compensation claim? YES / NO

If yes: INSURANCE COMPANY _____ CLAIM # _____

CASE MANAGER: NAME _____ CONTACT NUMBER _____

PRIVATE HEALTH FUND _____

FAMILY DOCTOR _____ LAST VISIT DATE _____

Please circle any of the following medical tests which have been performed in the **last 3 months**:

Blood Pressure	Blood Test	Breast Exam	Bone Density (Osteoperosis)	X – Ray	Prostate Exam

Do you have any illnesses? _____

_____

_____

Please circle if you have any conditions involving the following systems:

Ears	Eyes	Nose	Throat	Respiratory (Lungs)
Cardiovascular (Heart)	Digestive (Stomach)	Bowel	Bladder	Endocrine (Hormones)
Skin	Vascular (Blood/vessels)	Genitals	Psychological	

--- PLEASE READ AND SIGN CONSENT FORM OVERLEAF ---

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Patient Information and Consent to Chiropractic Care

Chiropractic care is a safe, conservative and non-invasive form of health care. In fact studies have shown that for the treatment of neck and/or back pain a course of Chiropractic care is 250 times safer than a course of anti-inflammatory drugs (Dabbs, et al. JMNT vol 18-8 1995).

However there are risks associated with all health care procedures and practitioners who manipulate the spine are required to warn patients of material risks. This consent form is provided to inform you of the most common risks associated with manipulative therapy. This form does not waiver your Common Law Rights; it is for you to acknowledge that you have been informed of the most common known risks and that you understand that individual responses vary and results are not guaranteed.

In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke-like symptoms. The chances of this are estimated to be between 1 in 1-2 million (D. Chapman-Smith seminar 2002) and 1 in 5.85 million (Haldeman, et al. Spine vol 24-8 1999). Vertebral artery testing and provocation tests for the neck will be undertaken and although they are not 100% predictive, they are the best manual screening procedures currently available.

Other slight risks include but are not limited to:

- strains/injury to a ligament or disc in the neck (less than 1 in 139,000) and the low back (1 in 62,000 Dvorak Study in Principles and Practice of Chiropractic, Haldeman 2nd Ed.)
- For some patients, especially those with bone weakening conditions, a fracture of a bone although rare is possible
- Muscle and joint soreness, nausea and dizziness, nerve irritation, exacerbation and/or aggravation of the underlying condition
- Dry needling potential risks include a puncture of the lung (pneumothorax), bruising and infection.

These episodes may result in outcomes such as referral, further tests, surgery, incapacity and the like.

It is also clear that there are many alternatives to treating musculoskeletal injuries. We always attempt to choose the most appropriate and effective treatment approach.

Please Complete

I have had the opportunity to read and discuss the above information with the chiropractor and give my voluntary consent to proceed with examination and treatment (by this or any other chiropractor working in this clinic). I understand that I can withdraw consent at any time after discussing it with the chiropractor.

Patient's signature_____ Print Name_____

Parent/Guardian's signature (under 18 years)_____

Print Parent/Guardian Name (under 18 years) _____

Chiropractor's signature_____ Date_____/_____/_____