New Patient Consent

GWYDIR CHIROPRACTIC & PHYSIOTHERAPY

Date: _____

Title: _____ First name: _____ Surname: _____

Date of Birth: ____/____/_____ Medicare No: _____IRN:____ Expiry date:_____

Address: _____

Suburb: _____ Postcode: _____

Phone number: _____ Mobile: _____

Email: _____

(Chiropractor/Physiotherapist or staff will send recommended Stretches & Exercises)

Occupation: _____ Your general practitioner: _____

Emergency contact name & relationship: _____

Emergency contact number: _____

Name of private health fund (if applicable): _____

Who is responsible for this account? _____

When did you last see a Chiropractor? _____ Date of last x-rays: _____

How were you referred to our office? _____

Please list any medications/drugs you are currently taking:

_____

_____

Reason for the medication: _____

Accidents, traumas, poor posture and on-going stress can result in spinal misalignment.

Please list the main traumas your spine has been subjected to, your age at which this occurred and the severity of the trauma. Don't forget your previous falls, sporting injuries, car accidents, etc…

_____

_____

What is your Major Complaint today? _____

When did this begin? _____

What do you think caused this complaint? _____

What treatment have you had for this problem? _____

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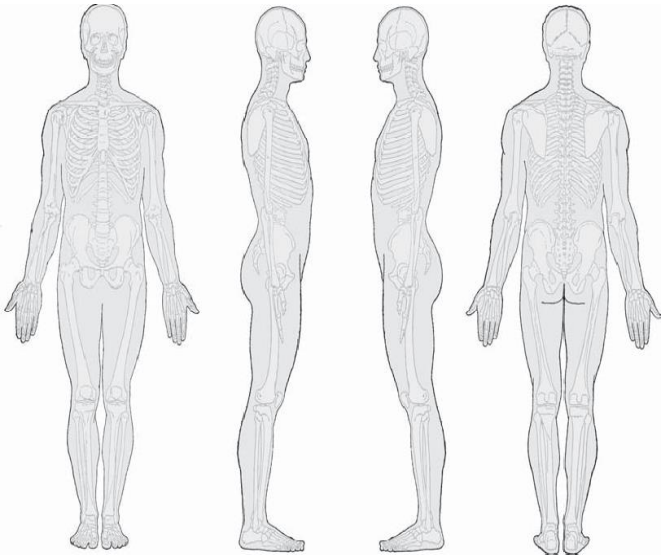
Please Mark on the picture below the areas where you are experiencing pain:

Front ***Right Side*** ***Left Side*** ***Back***



0 = No Pain
1 = Minimal
2 = Very Mild
3 = Mild
4 = Mild to Moderate
5 = Moderate
6 = Moderate to Severe
7 = Moderately Severe, restricts some activity
8 = Severe – limits most activity
9 = Very severe
10 = Excruciating

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain, use the key to the right and rate your severity of pain:

Right Now, what is the intensity of your pain?

0..... 1..... 2..... 3..... 4..... 5..... 6..... 7..... 8..... 9..... 10.....

What is the most intense this problem has been?

0..... 1..... 2..... 3..... 4..... 5..... 6..... 7..... 8..... 9..... 10.....

Have you experienced these symptoms before? ☐ Yes ☐ No

If yes, when? _____

What makes this condition worse (e.g. bending, lifting, coughing) _____

What makes this condition better (e.g. rest, ice) _____

Does this condition interfere with your sleep? ☐ Yes ☐ No

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No

Does the pain radiate anywhere? ☐ Yes ☐ No If yes, where? _____

Do you have numbness or tingling in the legs or arms/hands? ☐ Yes ☐ No Explain_____

Is your blood pressure? ☐ Normal ☐ Low ☐ High ☐ Don't Know

Have you ever had any hospitalization or surgeries? ☐ Yes ☐ No If yes, please list, with date if possible_____

New Patient Consent

GWYDIR CHIROPRACTIC & PHYSIOTHERAPY

NEW PATIENT CONSENT TO X-RAY & TO EXAMINATION AND CHIROPRACTIC CARE

Patient Name: _____ **Sex:** _____

Date of Birth _____ **Clinic ID #** _____

Changes to the law now require all practitioners who take x-rays and adjust the spine to warn patients of material risks.

The Risk Associated with Chiropractic Care

In extremely rare circumstances, chiropractic care of the neck may damage blood vessels and give rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments are required, you will be tested beforehand, as has always been our practice (i.e. check for dizziness, referred pain, etc). 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).

Chiropractic adjustments of the spine are internationally recognized 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, 1994. Manga Report, Ontario Ministry of Health, 1993). If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to your chiropractor.

The Risk Associated with X-ray

Generally, the benefit of the X-ray procedure is far more important than the small estimated risk. At the radiation dose levels that are used in diagnostic radiography there is little or no evidence of adverse health effects. There are two major risks to health that occur as a result of exposure to medical ionizing radiation (which is the kind of radiation in X-rays). These are cancer occurring many years after the radiation exposure and health problems in the children born to people exposed to radiation because of damage to the reproductive cells in the body. Medical research has as yet been unable to establish conclusively that there are significant effects for patients exposed to ionizing radiation at the doses used in diagnostic imaging. In addition, the dose of radiation that you receive from X-rays is very much lower than for other types of radiology procedures such as Computed Tomography (CT) scanning or angiography (X-ray examination of the blood vessels).

To put this all into perspective, a patient would need to have approximately 38 chest X-rays to receive an amount of radiation similar to that of normal background radiation that everyone receives for one year from the environment (ARPANSA 2008). This is very encouraging and supports the use of the small doses involved in diagnostic radiography.

What are the benefits of X-rays?

The benefits of X-ray are:

X-ray imaging is useful to diagnose disease and injury fractures, bone infections, arthritis, etc.

X-ray imaging is fast and easy so it is particularly useful in emergency diagnosis and treatment.

X-ray equipment is relatively inexpensive and widely available in hospitals and X-ray clinics and other locations, making it convenient for both patients and doctors, even in remote locations.

I consent to Chiropractic Care any X-rays that may be required and state that I have read and understood the possible risks involved. ☐

If I am female I certify that I am not pregnant. ☐

Patient's Signature: _____ **Date:** _____

(Parent or guardian signature required if under 15 years old).

Chiropractor's Signature: _____ **Date:** _____

Office Use Only:

☐ ROF ☐ OPAL ☐ Full Spine ☐ Individual ☐ 1 Region ☐ 2 Regions Type: _____ ☐ Nil