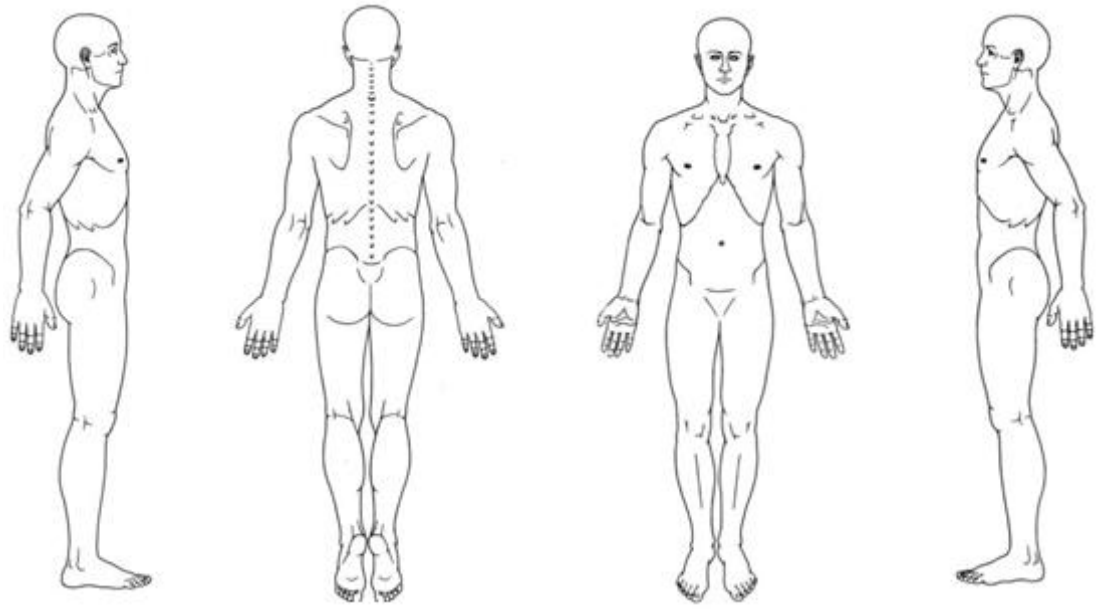
connecthealthcare

chiropractic new patient form

general information

Full Name: _____ Date of Birth: _____ / _____ / _____



please indicate on the diagram above the location of your pain / discomfort

Major issue: _____

_____

Has this occurred before? Yes / No How many times previously? _____

What caused this issue? _____

When did it begin? _____

Have you received any other treatment for this issue? _____

Do you smoke? Yes / No *If yes, amount per day:* _____

Do you consume alcohol? Yes / No *If yes, amount (glasses) per day:*_____ *or per week:* _____

Do you take any recreational or non-prescription drugs? Yes / No

What are your health and lifestyle goals? _____

_____

Have you experienced any of the following in the past month or since the onset of your main presenting health problem?

	YES	NO
Nausea or vomiting		
Fever or rashes		
Fatigue not resolved by sleep		
Weight loss or gain		
Dizziness, vertigo or light-headedness		
Difficulty breathing		
Chest pain or discomfort		
Fainting or loss of consciousness		
Decreased urinary or bowel control		
Pain or blood loss during urination or bowel movements		

Have you ever been diagnosed with any of the following health problems?

	YES	NO
High blood pressure		
High cholesterol or triglycerides		
Stroke, TIA or aneurysms		
Anaemia (low iron levels)		
Thyroid problems		
Cancer		
Diabetes or abnormal blood sugar levels		
Allergies or other immune related conditions		
Other vascular or systematic conditions		
Bone or joint diseases (osteoporosis, arthritis etc.)		

Do you have any family history of:

	YES	NO
Blood disorders		
Heart conditions		
Diabetes		
Stroke		
Autoimmune diseases		
Epilepsy		
Genetic disorders		
Cancer		
Nervous system disease		
Muscle, bone or joint conditions		

Do you currently suffer from any of the following?

	YES	NO
Unexplained fevers		
Night sweats		
Abnormal bleeding		
Unexplained weight loss or gain		
Pain causing you to wake at night		
Sudden onset of an intense headache you have not had before		
Difficulty with bowel or bladder control		

patient information

Please read the following information carefully before signing.

Risks of care & consent for care

Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications.** This may include, but are not limited to: soreness; muscle, bone or joint injury; worsening of symptoms; intervertebral disc injuries; nerve injuries; dizziness / light headedness; nausea; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended.

Dry needling can occasionally cause temporary local swelling, bruising or transitory increases in the levels or distribution of pain or other symptoms. In very rare cases dry needling has been reported as being associated with bodily infections

or collapse of a lung (less than 1 in 70 000- 1.27 million). Allergic skin reactions to massage oils, strapping tapes, dry needling needles or topical applications are also a possibility.

If I have any concerns, I will discuss them prior to treatment or during the course of a treatment program if any new concerns arise.

I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able** to **anticipate all potential risks** and complications associated with the proposed care.

I hereby acknowledge my consent to undergo assessments - which may require photographic or video recording as part of my records - and treatment at this clinic. I intend this consent form to cover the entire course of treatment for my present complaint, and for any other future complaint(s) for which I may seek treatment. I understand that I may withdraw my consent at any time without compromising my care in any way.

Patient Name: _____ Date: _____

Signed: _____