GENTLE CARE CHIROPRACTIC
NORWEST
Health Solutions with Care

CONFIDENTIAL PATIENT INFORMATION

All our patient records are held private and confidential in accordance with National Privacy Principles of the Commonwealth of Australia privacy legislation.

NAME ______________________________ DATE ______________

DOB ______________ AGE______________ SEX M / F

ADDRESS______________________ SUBURB______________P/CODE_____

HOME PHONE ______________________ MOBILE ______________________

EMAIL ____

EMAIL TO SEND INVOICES TO (if same, please write "as above" else provided additional)

____

PREFFERED MEANS OF CONTACT: PHONE EMAIL POSTAL MAIL OTHER

If you are active on social media, please circle: FACEBOOK TWITTER OTHER ______________

OCCUPATION ______________________________ WORK PHONE ______________

Are any of your work colleagues suffering from similar problems as you? Y / N

MARITAL STATUS ______________ CHILDREN ________ AGES ______________

EMERGENY CONTACT NAME______________________PHONE NUMBER ______________

RELATION TO YOU ______________________

YOUR HEALTH FUND ____

YOUR GP/MEDICAL DOCTOR: Name ______________________________

Clinic Name and Address ______________________________________

______________________________Phone______________________

Do you consent to us contacting your GP if required? Y / N

How did you find out about us (who referred you)? ______________________________

Have you ever received chiropractic care before? Y / N

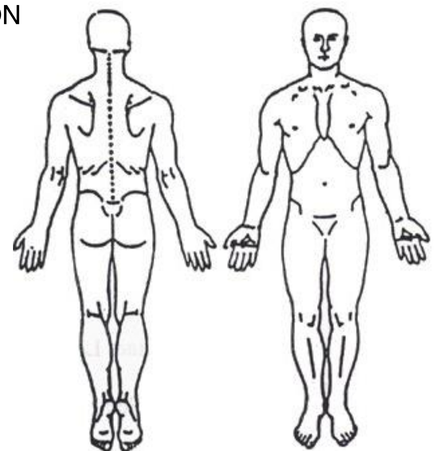
If yes, from whom ______________________________ Last adjustment ______________

YOUR HEALTH CONCERNS - My reason(s) for coming to this clinic today are:

☐ SPECIFIC PROBLEM ☐ WELLNESS and/or INJURY PREVENTION

If for a specific problem, please describe below →
(and indicate areas of dysfunction on diagram if relevant)

____
____
____
____
____
____



Please rate your pain/discomfort out of 10 (0=good, 10=bad)

0 1 2 3 4 5 6 7 8 9 10

Since the onset (or within a month) of your current health problem have you had any (circle):

Nausea/vomiting Severe headaches Dizziness Fainting Lost consciousness
Loss of vision Loss of appetite Weight loss Chest pain Difficulty breathing
Fatigue not relieved by sleep Fever or rashes Decreased urinary or bowel control
Pain or blood loss during urination/bowel movements Numbness of the face/both sides of the body
Seizures (or fits)

GENERAL

Smoker: Y / N If yes, quantity per day ___________ Alcohol: Y / N If yes, quantity per week ___________

Prior diagnosed health condition(s): Y / N If yes, list ____

____

Medications: Y / N If yes list ____

Please list two hobbies/interest/activities that you pursue outside of work:

____

CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. You must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about. *Please read the following carefully:-*

1. I acknowledge that I have discussed with Dr Bryan Hornby the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.
3. I have had the opportunity to discuss the proposed care with Dr Bryan Hornby I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** eg between 1 in 2 million to 1 in 5.85 million -Haldeman,et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (**current statistics** eg less than 1 in 139,000) and the low back (**current statistics** eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."*
7. I have read the above information and I hereby acknowledge my consent to the performance of the proposed chiropractic care by Dr Bryan Hornby and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time. I intended this consent form to cover the entire course of treatment for my present condition(s), and for any future condition(s) for which I seek treatment.
8. By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

______________________________ ______________________________

Patient's Name (printed) Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

______________________________ ______________________________

Chiropractor's Name (printed) Chiropractor's Signature

* Your email address will be added to our email database for correspondence, invoicing and newsletters (you can unsubscribe at any time). Appointment reminders will be sent via SMS/email and other information by a variety of means (including postal mail).

FORM COMPLETE — THANK YOU. Please return to staff when completed.

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