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Address: 6 Blue Gum Terrace, Caboolture South, 4510
E-mail: info@vibrantfamilychiropractic.com.au
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CONFIDENTIAL PATIENT INFORMATION - Please complete all sections

Full name:	**Date:**
Address: Street City County Postcode	
Home phone:	**Work phone:**
Mobile phone:	**Date of birth:**
No. of children:	**Pregnant? Yes ☐ No ☐ Weeks:**
Please circle: Single / Defacto / Married / Divorced / Widow	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	

Who may we thank for referring you? ______________________________

Have you ever received chiropractic care? **Y / N** From Whom and when?______________________________

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "**General Health History**".*

Health Concerns

Please list your health concerns according to their severity	When did this episode start?	How did this episode start?	If you had this condition before, when?	% of the time pain is present
1.				
2.				
3.				

Rate your pain for each health concern (please mark a score for each of the concerns you listed above):

No Pain ______________________________ Extreme Pain
0 1 2 3 4 5 6 7 8 9 10

Please mark the exact area/s you are having concerns with on the figure below.
Indicate any painful radiations with arrows.

Is your pain (please circle):
dull ache / sharp stabbing / electrical shooting / burning

What makes it worse? ______________________________

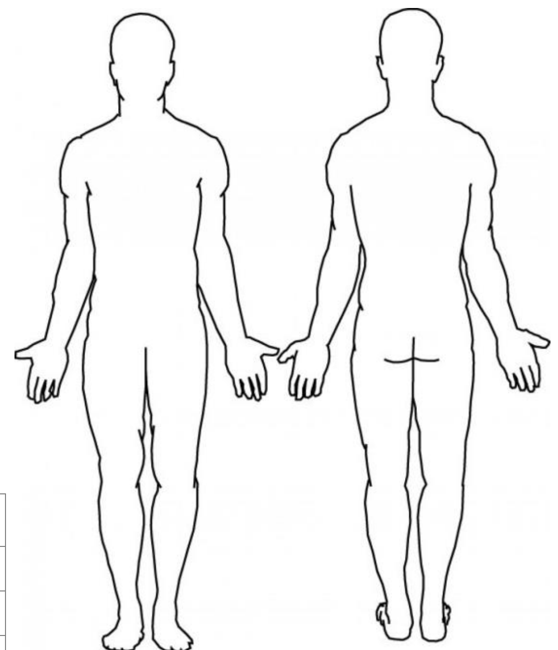
What makes it better? ______________________________

Since the problem started is it:

About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?
____

I do ☐ do not ☐ have a family history of this or similar symptoms
(Please explain): ______________________________
____



Have you consulted a Doctor about your current health concern? ☐
Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Why are you here / addressing these concerns, at this point in time?
____
____

General Health History

Often times, throughout life, your body is exposed to stress that can affect your ability to be healthy. The following questions will help to give us an idea of the potential layers of damage that can result in poor health and nervous system function. Please pay close attention to this as it will help us help you.

Have you had any surgery? Please list any surgery and the dates.
____

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems)
Please list and date____
____

Stressors

There are three different forms of stress that we encounter. Accumulation of stress can impact your health expression and ability to heal. Please list your top 3 stressors in each category:

Stress	Physical (falls, work, sport etc)	Biochemical (smoke, unhealthy food, lack of water etc)	Mental/emotional (finances, relationships, work etc)
1			
2			
3			

Is there anything else which may help to better understand you that has not been discussed?
____
____
____

Past Health History - Please mark the following conditions you may have had or have now (**-** have had / **+** have now):

- ☐ Alcoholism
- ☐ Allergy
  details:
- ☐ Anaemia
- ☐ Anxiety
- ☐ Atherosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
  details:
- ☐ Concussion
- ☐ Connective Tissue Disorders
- ☐ Constipation
- ☐ Convulsions
- ☐ Depression
  medication? Y or N
- ☐ Diabetes
- ☐ Diarrhoea
- ☐ Digestive Issues
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gall Bladder Problems
- ☐ Glandular Fever
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irregular Periods
- ☐ Malaria
- ☐ Measles
- ☐ Menstrual Cramps
- ☐ Migraines
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neck Pain
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Issues
- ☐ Ringing in Ears/Tinnitus/Vertigo
- ☐ Sinus Problems

Other (please explain) ____
____

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)
____
____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:
____
____

Health Goals

What are your health goals short term? ____
What are your health goals long term? ____
If you were functioning at 100% health and wellbeing what would you be doing in life? (passions, hobbies, sports etc)
____
____

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Informed Consent to Consultation, Examination and Initial Chiropractic Care:

Chiropractic care is recognised as being an effective and safe form of health-care. We pride ourselves in this office on providing all the information you need and want at all times, and hence we want to inform you of the conditions of consent to care:

The greatest care and attention will be given in all circumstances, however as with all healthcare options there are some very slight risks with chiropractic care. This includes but is not limited to:

- Minor muscles aches and inflammation (like in the days after a gym workout)
- Your condition becoming worse (sometimes people feel worse while healing is occurring)
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 cases - Neck, 1 in 62,000 cases - Low Back)
- Stroke or stroke-like symptoms (very rare - approximately 1 in 6,250,000 or 6.25 million neck adjustments)

*Put in context, **chiropractic care has been shown to be 250 times safer** than anti-inflammatory drugs and safer than driving a car.*

Declaration: I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely of the chiropractor to exercise his/her best judgment during the course of procedures which they feel, at the time, based upon the facts known, is in my best interests.

I have to the best of my knowledge, provided the chiropractor with a complete and accurate health history, and read the above consent. I understand that I will have ample opportunity to discuss the nature and purpose of my care with the chiropractor before any care is given, and that results are not guaranteed. I intend this consent to cover the entire course of my care at this office. Practice based research is regularly conducted in this practice, and I consent to my data, minus any personal identification, being used for research purposes.

I consent to a professional and complete chiropractic examination, scans and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

By signing below I agree to chiropractic care:

Print Patient Name: ____ Date: ____________________
Signature: ____

If the patient is under 16 years of age, this form should also be signed by a parent or guardian who consents to care on behalf of the minor, and who is validly able to do so.

Parent/Guardian Name: ___________________________Signature: _______________________ Date: _________________________