FORTITUDE
CHIROPRACTIC

PATIENT INFORMATION

Please print clearly & fill in all sides completely

Name ______________________________ **Email** ______________________

Address ____

Suburb ______________ **State** _______ **Postcode** _______ **Date of Birth** ____________ **Age** ________

Phone (Hm) ________________ **(Wk)** ________________ **(Mob)** ________________

Please tick ✓ **Sex**: Male ☐ Female ☐ **Marital Status:** Married ☐ Single ☐ Other ☐

Where did you hear about our clinic / who referred you?

Google ☐	Bing ☐	Facebook ☐	Friend ☐	Sign ☐	Doctor ☐	Other ☐ ________________

Which private health fund are you currently with? ______________________________

HEALTH HISTORY

Main reason for seeking chiropractic care: ______________________________

Is the above associated with a related event (e.g. head injury)?

☐ Yes ☐ No If yes, please explain: ______________________

Are the symptoms: ☐ constant ☐ variable (i.e: comes and goes)

Are you claiming through workers compensation or other insurance companies? ☐ Yes ☐ No

Describe any health problems, including how long you've had them:

____

Circle/mark the areas where you have any problems

Current pain level: (please circle)

No Pain					Moderate Pain					Worst Pain
0	1	2	3	4	5	6	7	8	9	10

What do you expect from your management? ________________

Are you under the care of any other doctor? Yes ☐ No ☐

If yes, the condition being treated: ______________________

Who is your GP? ______________________ **Practice Name:** ______________________

Current Medications: ____

Past surgeries & dates: ____

Past accidents & dates: ____

Did / Do you smoke? Yes ☐ No ☐ If so, No. per day ________ Years _________

Did / Do you drink alcohol? Yes ☐ No ☐ If so, No. units per day ____________

FEMALES: Is there a possibility of you being pregnant? Yes ☐ No ☐ Unsure ☐

Do you take the Contraceptive Pill? Yes ☐ No ☐ if so, when did you start? ________________

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? Yes ☐ No ☐ If yes, Doctor's Name ____________________

Date of last visit? _________ Reason for care? __________________________ How long under care? ________

Are other family members under Chiropractic care? Yes ☐ No ☐ If yes, who? ______________________

Have X-rays or other imaging been taken? Yes ☐ No ☐ If so, dates? ______________________________

FAMILY HISTORY

(Tick which applies to any close family member eg. Father, Mother, Grandparent)

☐ Scoliosis ☐ Arthritis ☐ Cancer ☐ High Cholesterol ☐ Osteoporosis
☐ Depression ☐ Stroke ☐ Hypertension ☐ Diabetes ☐ Heart Conditions
☐ Migraines ☐ Muscle Disease
☐ Other ________________________________ Type of Relation: ____

WORK

Your Occupation _____________________________________ **Work Duties** _____________________________________

Indicate whether your job involves the following and state the hours spent doing each of these daily duties:

☐ Heavy Lifting ___ hrs ☐ Bending ___ hrs ☐ Twisting ___ hrs ☐ Vibration Equipment __ hrs
☐ Sitting ___ hrs ☐ Standing ___ hrs ☐ Walking ___ hrs ☐ Driving ___ hrs

CURRENT MEDICAL HISTORY

(Please tick all that apply to you)

Symptom, Problem	Frequently	Occasionally	Never	Details
Headaches / Migraines	☐	☐	☐	
Neck Pain	☐	☐	☐	
Shoulder Pain	☐	☐	☐	
Arm / Hand Pain	☐	☐	☐	
Mid / Low Back Pain	☐	☐	☐	
Hip Pain	☐	☐	☐	
Leg / Foot Pain	☐	☐	☐	
Disc Problems	☐	☐	☐	
Arthritis	☐	☐	☐	
Insomnia	☐	☐	☐	
Heart / Lung / Chest Problems	☐	☐	☐	
Menstrual Issues	☐	☐	☐	
Allergies	☐	☐	☐	
Ringing in Ears	☐	☐	☐	
Urinary Problems	☐	☐	☐	
Condition	**Yes**	**No**	**Unsure**	**Details**
Cancer	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Diabetes	☐	☐	☐	
Asthma	☐	☐	☐	
Abnormal Blood Pressure	☐	☐	☐	
Unexplained weight loss	☐	☐	☐	
Stroke / Stroke-like symptoms	☐	☐	☐	

Have you had any of the following **UNRELATED to any underlying condition and / or medication RECENTLY?**

(Please Circle)

Dizziness or vertigo	**Y/N**	Loss of consciousness or frequent fainting?	**Y/N**
Unsteadiness on your feet / difficulty walking	**Y/N**	Numbness on side of the face or body	**Y/N**
Double vision / Visual Disturbances	**Y/N**	Nausea or vomiting	**Y/N**
Problems swallowing or speaking	**Y/N**	Are you on Hormone replacement therapy?	**Y/N**

Details: ____

CONSENT FOR CHIROPRACTIC CARE

Changes to the law now require all practitioners who manipulate the spine to inform patients of any potential risks no matter how small. Any health care intervention attracts some risk. Listed below are some significant Chiropractic risks with comparisons to some common medical risks to put the issue into perspective.

CHIROPRACTIC		MEDICAL / OTHER	
Lumbar disc injury	1 / 62,000	Injury from car accident	1 / 9,300
Cervical nerve injury	1 / 39,000	Death from lightning strike	1 / 20,000
Lumbar nerve injury	1 / 188,000	Death from General Anesthetic	1 / 1,250
Loss of consciousness and spinal cord injury	1 / 382,000	Stomach bleeding from anti-inflammatories (1 month)	1 / 250
Death from stroke	Between 1 / 1 million and 1 / 5.8 million	Death from anti-inflammatories	360/year

Possible Adverse Outcomes

1. In a minority of cases treatment may not be successful and you may be in the same position you are currently in.
2. Uncommonly, your condition may worsen:
    a. 1 in 3 patients (33%) report *temporary soreness, tenderness / bruising*.
    b. Some patients *report fatigue, headaches, dizziness or nausea* following treatment. These symptoms **usually resolve completely within 24 hours** after the treatment.
    c. While rare, some patients have reported *rib, shoulder, and chest or knee pain* following spinal manipulation. These symptoms **usually resolve within 2 days** after the treatment.
    d. There is a slight risk of *sprain/strain injury to a ligament or disc in the neck or lower back*. These are **rare**, but can cause nerve pain with radiation of pain into the arms, trunk or legs. Bowel or bladder function can be affected and erectile dysfunction has been reported, but is **very rare**.
    e. In the case of manipulation of the neck, there is *risk of injury to arteries in the neck*. These are very **rare events**. If they occur they have been known to cause stroke or stroke-like symptoms such as **quadriplegia or death.** The risk of these events is between **1 in 1 million and 1 in 5.8 million**.

Although we have asked screening questions and performed physical and orthopedic tests, there is no way of guaranteeing that you will not suffer one of these extremely rare events.

If you have any further questions regarding the above information, please ask your chiropractor.

I ______________________________________ understand the risks associated with Chiropractic care and declare this information is a true and accurate record of my health history.

Patient Name: _____________________________________

Patient Signature: ___________________________________ Date: _____/___________/______

Privacy and Compensation Agreement

I hereby authorize any therapist, whether named in this certificate or not, to communicate and share information with my general practitioner or other health care provider to assist in my care. Payment on the day is by Cash or EFTPOS only, a **$40.00 missed appointment fee applies if less than 24 hours' notice is given**.

I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment after each treatment. If an account remains unpaid, I will be responsible for all collection and administration fees.

Patient Signature: ___________________________________ Date: _____/___________/______