COUNTRY CHIROPRACTIC

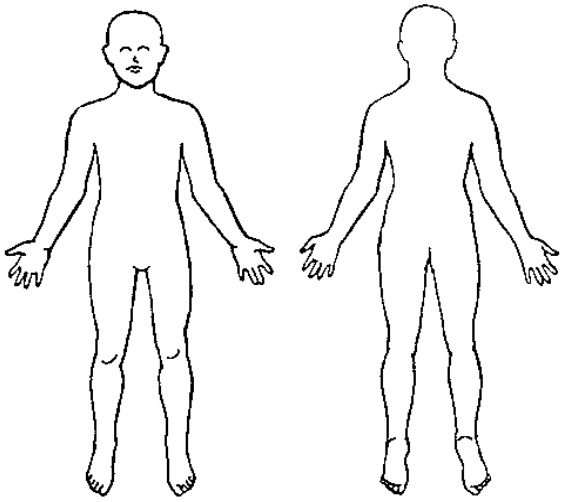
PHYSIOTHERAPY
PATIENT INTAKE INFORMATION

Date: ___/___/___

NAME:	**SEX: M | F**	**DOB:**	**AGE:**
Address:			**Postcode:**
Phone (Home):	**Phone (Work):**	**Mobile:**	
Email:			
Partners name:			
Children (List + Ages):			
Emergency contact name and number:			
OCCUPATION:	**EMPLOYER:**		
How did you find our clinic? Person:	Website Signage Facebook Other:		
Is this (circle): workers compensation/ motor vehicle/ Medicare/ DVA			

WHAT IS YOUR MAJOR HEALTH CONCERN?

Please indicate & circle where your present symptoms are on the diagram below using the symbols in the below



Aching Pain: A
Burning Pain: B
Stabbing Pain: S
Numbness/Pins/Needles: P
Other: (use your imagination)

Indicate the intensity of your pain below (circle):

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** WORST PAIN

Main Concern:

When did it start?

Have you had it before? **Y** **N**

Is it (circle): getting worse constant comes/goes getting better

What caused it / How did it happen?

Is the pain referring to other areas of your body?

What makes it better?

What makes it worse?

What treatment have you had? (circle) GP Chiro Physio Other:

How have these problems interfered with your activities?

Sporting ability / Fitness / Work ability?

Sleeping Posture: (circle) Side Back Stomach

Sports you play or used to play:

OTHER PROBLEMS: (please tick and elaborate if necessary)

- ☐ Neck pain
- ☐ Mid-back pain
- ☐ Low back pain
- ☐ Other joint pain:
- ☐ Numbness or Tingling
- ☐ Scoliosis
- ☐ Spinal Surgery
- ☐ Osteoarthritis / Osteoporosis
- ☐ Rheumatoid / Psoriasis
- ☐ Cancer / Malignancy
- ☐ Stroke
- ☐ Asthma or Breathing Difficulty
- ☐ Lung or Chest problems
- ☐ Abdominal pain
- ☐ Digestive issues
- ☐ Kidney, bladder issues
- ☐ Reproductive issues
- ☐ Heart or circulatory issues
- ☐ Blood pressure issues
- ☐ Headache or Migraine
- ☐ Dizziness or Vertigo
- ☐ Epilepsy
- ☐ Sinusitis or Hay Fever
- ☐ Eyes, ears, nose, throat issues
- ☐ Skin issues
- ☐ Allergies
- ☐ Weight issues
- ☐ Anxiety/Depression
- ☐ Tired/Fatigued
- ☐ Difficulty sleeping

GENERAL HEALTH: (please answer to the best of your ability)

Current Health Care Practitioners: (who, and what for?)

List Vitamins/Supplements:

List Current Medications (including contraception):

List all injuries:

Major Illnesses during lifetime:

Detail any motor vehicle accidents / other injuries:

List surgeries or hospital stays:

List previous x-rays, CT scans, MRI's:

Do you currently smoke? (circle) **Y** **N** How many? (per day) Did you Previously?

Do you drink alcohol? (circle) **Y** **N** Total per day? (Std Drinks)

Do you wear shoe inserts or Dental splints? (circle) **Y** **N** Details:

Apart from usual medical details, it is important that you must answer these questions

Are you a diabetic:	**Y**	**N**
Have you ever experienced a fit, faint or funny turn:	**Y**	**N**
Have you been fitted with a pacemaker or any other electrical implants:	**Y**	**N**
Do you have a bleeding disorder:	**Y**	**N**
Are you taking anticoagulants or other medication:	**Y**	**N**
Do you have damaged heart valves or have any other particular infection risk	**Y**	**N**
Are you pregnant or actively trying for a pregnancy:	**Y**	**N**
So you suffer from medical allergies:	**Y**	**N**
Do you know of any reason why you shouldn't have acupuncture:	**Y**	**N**

Anything else you would like us to know?

MISSED APPOINTMENT & PRIVACY POLICIES

I am aware of the Missed Appointment Policy and associated fees.

I consent to the collection of my personal information as outlined in the Privacy Policy.

Patient/ Guardian's Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

Please refer to our informed consent document and appropriate discussions with your practitioner.

Consent to Acupuncture/ dry needling

Acupuncture is a form of therapy in which needles are inserted into specific parts of the body and is generally very safe. Serious side effects are very rare – less than 1 per 10,000.

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients and if affected, you are advised not to drive.
- Minor bleeding or bruising occurs after Acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Existing symptoms can get worse after treatment. You should tell your physiotherapist about this, but it is usually a good sign.
- Fainting can usually occur in certain patients, particularly at the first treatment.
- Single-use, disposable needles are always used in this clinic

I do **not** consent to the use of: Dry Needling (circle if needed)

Patient/ Guardian Name Signature Date

Physiotherapists Signature Date