Absolute Health
Chiropractic & Physiotherapy

Mooloolaba Clinic
1/11 Walan Street
Mooloolaba, 4557
Ph: 07 5478 2333

Noosa Medical Centre
Suite 6, 1 Lanyana Way
Noosa Junction , 4567
Ph: 07 5478 2333

E: info@absolutechiropractic.com.au
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New patient intake form:

Welcome to Absolute Health Chiropractic & Physiotherapy. To enable us to assist you in reaching your health goals please take a few minutes to answer **all** the following questions as accurately as you can. Your answers will help determine how to best help you.

Patient details:

Full Name: _____ DOB: _____ Male ☐ Female ☐

Address: _____

Town: _____ Postcode _____

Phone: (M): _____ (H): _____ (W): _____

Occupation: _____ E-mail: _____

Status: Single ☐ Married ☐ Cohabitation ☐ Widow ☐

Partner's name: _____ Children & ages _____

Are you claiming part or full payment of care: No ☐ Yes ☐ If yes, please choose below

Private Insurance ☐ Insurer _____

DVA ☐ Workcover ☐ Medicare (EPC/CDM) ☐ Other _____ ☐

GP Name: _____ Medical Centre: _____

Permission to contact (if req) Yes ☐ No ☐

How did you find out about our clinic: _____

Is there any chance that you are pregnant: Yes ☐ No ☐

Health Questionnaire:

Reason attending clinic: Optimal health / prevention ☐

Specific Health concern ☐ (please fill in details below)

Reason for attending our clinic (if for a specific health concern):

_____

When did this problem start _____ **OR** Ongoing condition ☐

Please list any:

1. Previous surgery _____
2. Significant trauma / injury _____
3. Medications (within the previous 6 months) _____
4. Previous treatment _____
5. Significant illness or disability _____

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General health questionnaire:

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of your condition. Please tick the appropriate box if you have had any of the following symptoms in the past **12 months**. **Leave blank any that do not apply.**

Please tick (one box only) based on if the symptom occurs:
(O=Occasionally, F= Frequently, C=Constantly)

O	F	C	**Head/Neck**
☐	☐	☐	Headaches
☐	☐	☐	Light Headed
☐	☐	☐	Loss of Balance
☐	☐	☐	Hearing Loss
☐	☐	☐	Ringing in Ears
☐	☐	☐	Buzzing in Ears
☐	☐	☐	Neck Pain / Ache
☐	☐	☐	Grating / Cracking in neck

O	F	C	**Shoulder, Arm, Fingers, Hands**
☐	☐	☐	Pain
☐	☐	☐	Pins and Needles
☐	☐	☐	Numbness
☐	☐	☐	Weakness / Loss of strength
☐	☐	☐	Restricted movement
☐	☐	☐	Swollen Joints

O	F	C	**Chest and abdomen**
☐	☐	☐	Pain/ tightness in chest
☐	☐	☐	Pain around ribs
☐	☐	☐	Shortness of breath
☐	☐	☐	Wheezing
☐	☐	☐	Rapid heart beat
☐	☐	☐	Thumping Heart beat
☐	☐	☐	Stomach/Abdominal pain
☐	☐	☐	Belching or excessive wind
☐	☐	☐	Nausea
☐	☐	☐	Abdominal organ problems
☐	☐	☐	Constipation or diarrhoea
☐	☐	☐	Hernia
☐	☐	☐	Groin or pelvic pain

O	F	C	**Low back, Legs or feet**
☐	☐	☐	Pain
☐	☐	☐	Pins & needles
☐	☐	☐	Numbness
☐	☐	☐	Restriction of movement
☐	☐	☐	Swollen Joints

O	F	C	**Geneto-Urinary System**
☐	☐	☐	Urinary problems or infections
☐	☐	☐	Difficulty starting or stopping urination
☐	☐	☐	Loss of control or urination
☐	☐	☐	Bed wetting
☐	☐	☐	Prostate problems

O	F	C	**Females Only**
☐	☐	☐	Painful, tender or lumps in breasts
☐	☐	☐	Menstrual problems or abnormalities
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful intercourse

O	F	C	**General symptoms**
☐	☐	☐	Allergies, sinus problems ect.
☐	☐	☐	Excessive fatigue
☐	☐	☐	Chills, fever
☐	☐	☐	Fainting
☐	☐	☐	Sudden, recent loss of weight
☐	☐	☐	Depression or mental illness
☐	☐	☐	Excessive sweating
☐	☐	☐	Vascular disorders
☐	☐	☐	High blood pressure (hypertension)
☐	☐	☐	Low blood pressure

O	F	C	**Neurological**
☐	☐	☐	Tremors
☐	☐	☐	Loss of balance
☐	☐	☐	History of stroke, TIA, thrombosis ect.
☐	☐	☐	History of cardiovascular disease

Please tick if **yourself (S) or Family (F)** have had the following:

S	F	
☐	☐	Cancer
☐	☐	Vascular of heart disease
☐	☐	Arthritis or joint problems
☐	☐	Neurological conditions
☐	☐	Other serious illness
☐	☐	Diabetes
☐	☐	Other _____

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Informed consent

Please read this form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Privacy Act 1988 (Commonwealth):
This office complies with the above act; Information provided by you is collected with a view to helping you with your health concerns. It is not used or disclosed to any third parties or organisations other than required by our professional advisors (e.g. insurers) or required by law. To keep you abreast of news, developments and activities at our office, you will be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities etc. Additionally, we may contact you in relation to your care. Please let us know if you would like us to remove you from this list.

Consent to examination:
I hereby acknowledge that all the information I have provided is accurate to the best of my knowledge. I also give my consent to any examination, including, not limited by physical examination, x-ray examination and physical tests deemed appropriate/necessary by the clinician.

Consent to treatment:
Any treatment provided at this clinic, including but not limited to spinal adjustment or manipulation, has been the subject of much research conducted over many years and has been demonstrated to be appropriate and effective treatment for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches, and other similar symptoms. Treatment provided at this clinic may also contribute to your overall wellbeing. The risk of injury or complication from manual treatment is substantially lower then the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Clinicians who use spinal manual therapy techniques, such as for example joint manipulation, adjustment or mobilisation, are advised to inform patients that there are or may be some risks associated with such treatment. In particular:

a) While rare, some patients have experienced muscle soreness, ligament sprains or strains, or rib fractures following spinal adjustments.
b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and/or mobilisation. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million to 2 million treatments.
c) There have been reported cases of intervertebral disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Acknowledgment: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of the treatment in general and my treatment in particular as well as the contents of this consent.
Consent: I consent to the treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation to the joints of my spine (neck and back), pelvis, and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatment at this clinic.

Date: *X*_____

Full Name (print): *X*_____

Signature of patient / guardian: *X*_____

Signature of clinician: _____

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