COMPLETE CARE HEALTH

Patient information

Date: ___ / ___ / ___

Name: _____ DOB: _____ Sex: M / F
Title *First* *Surname*

Full address *(inc Postcode)*: _____

Contact number: _____ Occupation: _____

E-mail: _____

Marital status: _____ Children: _____

Emergency name: _____ Relationship: _____Phone: _____

How did you learn about Complete Care Health? If referred by a friend, who *(full name please)*?

_____

Have you seen a Chiropractor/Physiotherapist before? Name: _____

Medical Doctor: _____

What is your present complaint? _____

How did it begin? _____

What is your goal from treatment? _____

How long do you think it will take to achieve this? _____

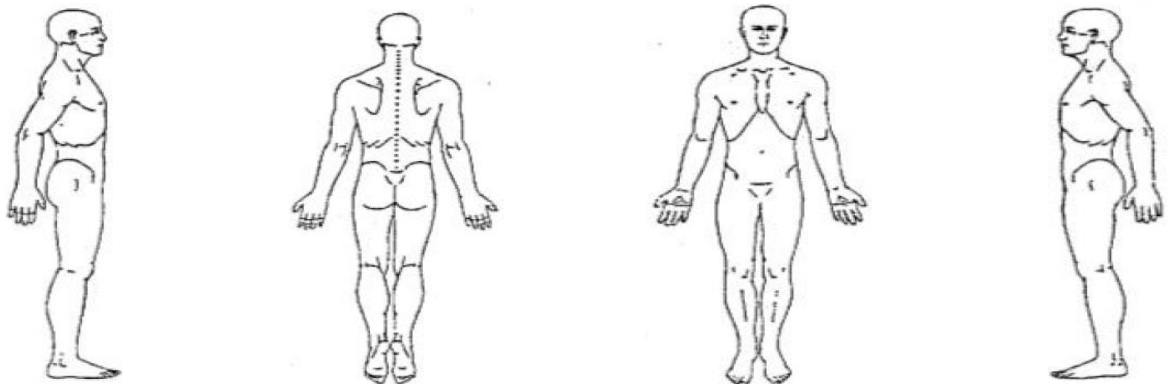
How long have you been experiencing the symptoms mentioned?

☐ Years _____ ☐ Months _____ ☐ Weeks _____ ☐ Days _____

Do you feel you are: ☐ Improving ☐ Getting worse ☐ No change

Please indicate the type of pain below and specify the area with the letter shown:

A – Ache
N – Numbness
B - Burning
S – Stabbing
P – Pins and Needles
O – Other _____



Place a mark on the line below indicating your pain level:

0 — 10

No Pain — Worst Pain

PTO

Practitioner comments – for office use only

Past medical history (please complete the following)

Any past surgeries, accidents, injuries, illnesses

Incident	*Year*

List of medications (prescription and non-prescription including vitamins, herbs, pain killers, blood thinners and contraceptive pill)

Medication	*Dose*	*Frequency*

List of recent diagnostic procedures (eg X-Ray's, MRI's, CT Scans, Ultrasound, Blood, Urine, Stool Tests)

Test	*Findings*

*Family History*_____

_____

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Medical conditions (tick which applies to you)

☐ Stroke	☐ Meningitis	☐ Anaemia	☐ Pacemaker
☐ High Blood Pressure	☐ Depression	☐ Anxiety	☐ Headaches
☐ Heart Disease	☐ Cholesterol	☐ Diabetes	☐ Multiple Sclerosis
☐ Seizures	☐ Gallstones	☐ Psoriasis	☐ Irritable Bowel Syndrome
☐ Crohn's Disease	☐ Asthma	☐ Eczema	☐ Ulcers
☐ Emphysema	☐Hernia	☐ Whiplash	☐ Urinary Infection
☐ Sciatica	☐ Arthritis	☐ Bursitis	☐ Carpal Tunnel

Please state any other conditions you may have:

_____

Please circle which applies to you: O-Occasionally, F-Frequently, C-Constantly

Altered Consciousness	O	F	C	Night Sweats	O	F	C
Dizziness	O	F	C	Loss of Taste	O	F	C
Ankle Swelling	O	F	C	Difficulty Concentrating	O	F	C
Chronic Cough	O	F	C	Groin Numbness	O	F	C
Difficulty Swallowing	O	F	C	Erectile Dysfunction	O	F	C
Altered Vision	O	F	C	Loss of Bowel Control	O	F	C
Chest Pain	O	F	C	Leg Weakness	O	F	C
Numbness	O	F	C	Lower Back Pain	O	F	C
Difficulty Speaking	O	F	C	Urinary Retention/Incontinence	O	F	C
Sudden Weakness	O	F	C	Diarrhoea	O	F	C
Jaw Pain	O	F	C	Heart Burn	O	F	C
Rib Pain	O	F	C	Bloating	O	F	C
Unexplained Weight Loss	O	F	C	Abdominal Cramps	O	F	C
Fatigue	O	F	C	Constipation	O	F	C
Difficulty Sleeping	O	F	C	Vomiting	O	F	C
Fever	O	F	C	Indigestion	O	F	C
Hand Tremor	O	F	C	Nausea	O	F	C
Difficulty Hearing	O	F	C	Testicular Pain	O	F	C

Lifestyle

Are you currently a smoker? ☐ Yes ☐ No

If yes, how many cigarettes/packs per day do you smoke? _____ For how many years? ___

If no, have you smoked in the past? ☐ Yes ☐ No. If yes, when did you stop? _____

How many? Standard alcoholic drinks _____ per day/week/month (circle one)

Litres of water _____ per day

Are you exercising regularly? ☐ Yes, duration ____ hrs/week ☐ No, last regular exercise ____

Average hours of sleep per night _____ Do you feel rested? _____

Do you have a supportive pillow: _____ Do you sleep on your: back / side / stomach (circle one)

PTO

Work

Indicate if your job involves the following and state the hours (per week) spent doing these duties:

☐ Heavy lifting ____ hrs ☐ Bending ____ hrs ☐ Twisting ____ hrs

☐ Vibration equipment ___ hrs ☐ Sitting ____ hrs ☐ Standing____ hrs

☐ Walking ____ hrs ☐ Driving___ hrs

Do you require sick leave for your current complaint? ☐ Yes ☐ No

Are you currently in litigation over your current complaint? ☐ Yes ☐ No

Rate your current stress level: ☐ None ☐ Minimal ☐ Moderate ☐ High

Understanding the risks of Manipulation & Dry Needling

Manipulation is a safe, effective and appropriate way to care for many spinal complaints.
The most common adverse effect of manipulation is *minor stiffness* after the first treatment, which affects about 4 percent of patients receiving manipulation. The most serious risk identified with cervical manipulation is a condition known as *vertebrobasilar stroke (VBS)*, which occurs more commonly with individuals suffering from artery disease. The risk of this complication arising from upper cervical manipulation is extremely unlikely. According to, "The Appropriateness of Manipulation and Mobilization of the Cervical Spine," between one in every million patients and one in every 3.8 million treatments may experience *VBS*. Lesser risks include; sprain, injury to a ligament or disc in the neck (less than 1 in 139,000) and lower back (1 in 62,000). Most patients receive cervical manipulation as for specific problems such as muscle tension, stiffness, headaches or injury, or part of their regular mobility maintenance.
The possible risks and adverse reactions to dry needling therapy include but are not limited to; temporary pain, bleeding, bruising, infection, dizziness, nerve injury, pneumothorax, changes to blood pressure, rash, fainting, muscle soreness & fatigue.
I hereby acknowledge and understand the above risks and, consent to undergo manipulative care and dry needling.

If you are about to receive clinical care, please tick one of the following

I consent to undergo clinical care **☐ Yes** **☐ No**

Are you pregnant? (Females only) **☐ Yes** **☐ No** **☐ Unsure**

Privacy and Compensation Agreement

I understand that my mobile number and e-mail address may be used for communication purposes within the clinic, if you don't wish for this to happen, please notify reception. I understand that any x-ray films taken are my responsibility to keep, while the medical report is the responsibility of the clinic. The clinic will hold any films for three months, and thereafter if they are not collected, they will be destroyed. I hereby authorise any therapist, whether named in this form or not, to communicate and share information with my general practitioner or other health care provider to assist in my care. I clearly understand and agree that all services rendered are charged directly to me and, I am personally responsible for payment to the clinic. (In the case of a minor, this must be signed by a parent or legal guardian).

Patient name: _____Signature: _____

Practitioner name: _____ Signature: _____

Date: / /