

**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? \_\_\_\_\_

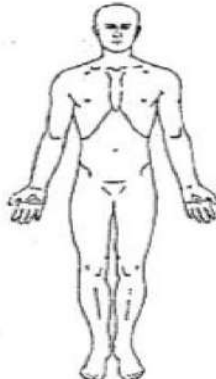
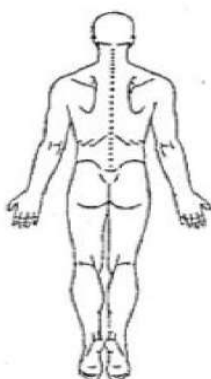
How long have you been experiencing the symptoms mentioned?

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  
No Pain

10  
Worst Pain

Past medical history (please complete the following)

Any past surgeries, accidents, injuries, illnesses

<i>Incident</i>	<i>Year</i>

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

<i>Medication</i>	<i>Dose</i>	<i>Frequency</i>

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

<i>Test</i>	<i>Findings</i>

Family History \_\_\_\_\_

Medical conditions (tick which applies to you)

- |  |                                      |                                    |   |
|--|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Meningitis  | <input type="checkbox"/> Anaemia   | <input type="checkbox"/> Pacemaker                |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression  | <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Multiple Sclerosis       |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Gallstones  | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hernia      | <input type="checkbox"/> Whiplash  | <input type="checkbox"/> Urinary Infection        |
| <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Bursitis  | <input type="checkbox"/> 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)

## 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:      /      /