Welcome to Vital Spines!

Your body is designed to be healthy. However, we experience physical, chemical and emotional stresses which can damage our health and quality of life. The effects are often gradual, accumulative and frequently are not felt until they become serious. The following questions will help uncover the layers of damage and your chiropractor will outline a course of care to begin to help correct these layers of damage.

PERSONAL DETAILS

Name				**Preferred Name**	
Address				**Tel (Home)**	
Suburb Postcode				**Tel (Mobile)**	
Date of Birth		**Age**		**Tel (Work)**	
Email				**Marital Status**	
The Office Newsletter will be sent to the email address provided				**No. of Children**	
Next of Kin				**Ages of Children**	
Occupation					
Emergency Contact Name and Relation				**Contact Number**	

How did you hear about us?

	Advertisement		**Referred by Another Patient** If so, by whom?
	Local Trader		**Internet Website/ Search Engine** If so, which website?
	Signage/Walk By		**Other** Please Specify

Have you received chiropractic care previously?

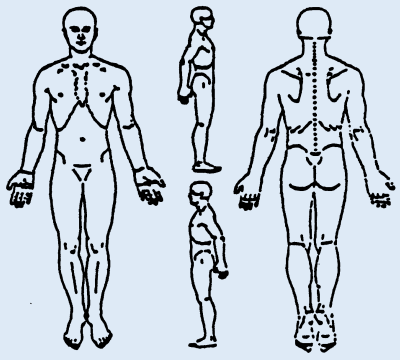
If yes, when was your last adjustment?	
From whom did you receive this care?	

HEALTH HISTORY

What are your main health objectives from attending this clinic?

	Relief of symptoms		Correction of an underlying issue		Maximise my / my family's health

What is the main reason for your visit? **Please indicate on the diagram where you experience your pain and/or symptoms**	....



When did this begin?	
How did this begin?	
Has this been an issue previously? If so, when?	
What (if any) activities aggravate the issue?	
What (if any) activities alleviate the issue?	
Indicate on the following scale how you rate your pain	No Pain 1 2 3 4 5 6 7 8 9 Extreme Pain

Nature of pain (please select all that apply)		Dull / Ache / Sharp / Throbbing / Constant / Intermittent						
Since it started, is it		Unchanged		Worsening		Improving		Intermittent
Have you consulted any other health professional for this use? If so, who?								
Please list any medications you are currently taking, and what they are for								
Please list any supplements, vitamins, herbs, or homeopathic remedies you are currently taking								
Have you ever had any of the following? If so, please describe what happened, and when:								
Injuries and/or accidents (including motor vehicle accidents)								
Fractures								
Operations and/or hospitalisations								
Illnesses and/or diseases								
Wisdom teeth removed and/or braces								
Do you have or have you had any of the following (please tick)								
	High/Low Blood Pressure		Reflux / Indigestion		Arthritis		Depression	
	Heart Attack		Thyroid Conditions		Allergies		Cancer	
	Stroke / TIA		Diabetes		Anxiety		Neurological Disorders	

FEMALES ONLY

Do you have or have you had any of the following (please tick)							
	Irregular Cycles		Polycystic Ovarian Syndrome				
	Heavy / Light Periods		Lumps in breasts				
	Endometriosis		Menopause				
Is there any chance that you may be pregnant (please circle)	Yes	No					
During gestation, were you:		Involved in any injuries or accidents?			Ill or under undue stress?		
Was the delivery:		Particularly Long		Particularly Rapid		Neither	
Did it involve:		Induced labour		Forceps/suction		Breach	Caesarian
Was the delivery:		Difficult		At Home		In Hospital	

LIFESTYLE HISTORY

Please select the options which apply to you:							
	Smoke		Drink tea/coffee		Experience Stress		
	Sleep Well		Exercise Regularly		Drink Alcohol		
Which sports/hobbies do you engage in?							
Please rate your current health	Poor Health 1 2 3 4 5 6 7 8 9 Excellent Health						

INFORMED CONSENT

When performed by a qualified Chiropractor, spinal manipulation (adjustments) are an effective and safe method of treatment for many conditions. There are, however, risks associated with treatment, and we are required to inform you of these.

I hereby request and consent to the performance of Chiropractic treatment by the qualified Chiropractors caring for patients at Vital Spines Chiropractic.

I understand, and am informed that, as in the practice of Medicine, in the practice of Chiropractic there are some very slight risks associated with assessment and treatment, including but not limited to, Muscle and joint soreness, muscle strain, joint sprain, fractures, disc injuries, nerve injuries, stroke and stroke-like episodes, and/or exacerbation or aggravation of the underlying condition.

I do not expect the Chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the Chiropractor to exercise judgement during the course of the treatment, which the Chiropractor feels at time, based upon facts then known, are in my best interest. I understand that results are not guaranteed.

I have read the above, and I have had the opportunity to discuss the nature and purpose of Chiropractic treatment and I have also had the opportunity to ask questions about its content.

I intend for this consent form to cover the entire course of my treatment for my present condition, and for any other future conditions for which I seek treatment.

I understand that I can withdraw my consent at any time

Patient Name (Please Print): _____

Signature of Patient/Guardian: _____

Signature of Chiropractor: _____

Consulting Chiropractor: _____

Date: _____