WELCOME- NEW PATIENT INFORMATION

CHARLTON CHIROPRACTIC
REDBANK
YOUR SPINAL HEALTH IS IN GOOD HANDS

NAME: _____

ADDRESS:_____

MOBILE: _____EMAIL:_____

OCCUPATION:_____ RELATIONSHIP STATUS:_____

NO OF CHILDREN: _____ DOB: _____ /_____/_____

HOW DID YOU FIND OUT ABOUT US? _____

WHAT BRINGS YOU IN TO SEE US?

_____

WHAT DO YOU THINK POTENTIALLY CAUSED THIS? (Injury, Accident, Work, Repetition)

_____

Describe your pain or problem, how does it feel?_____

On a Scale of 1 to 10 how bad is it now? (1- Minor _____ 10 -Very Painful)

Where else does your pain go?_____

How long have you had this problem? _____

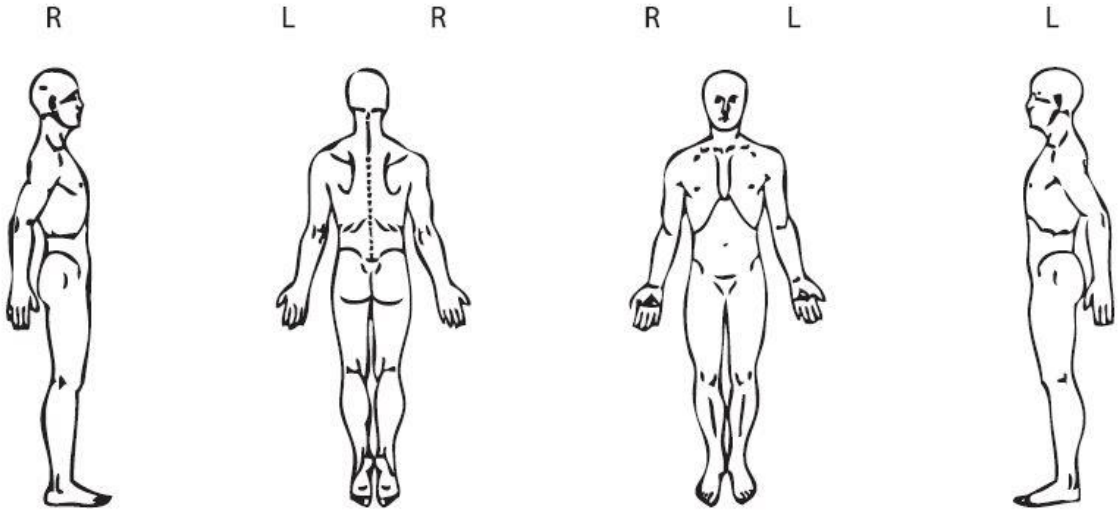
What **aggravates** your problem? _____

What **relieves** your problem? _____

What have you tried to help? _____

Who have you to help this? _____

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -



LIST ANY TRAUMA, MEDICAL DIAGNOSES, SURGERY or PROCEDUE

_____

PLEASE CIRCLE WHAT YOUR CONDITION INTERFERES WITH:

Sleep	Work	Concentration	Energy	Gym	Physical Activity
Self Care	Recreation	Home Duties	Patience	Productivity	Relationships

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST 6 MONTHS?(CIRCLE)

Low Back Pain	Sciatica	Hip Pain	Headaches	Dizziness	Tired/Fatigued
Poor Energy Levels	Sleeping Difficulties	Migraines	Neck Pain	Tension	

DO YOU HAVE ANY OF THE FOLLOWING? (CIRCLE)

Pain Waking @ Night	Cancer	Stroke	Change in Bowel or Bladder	Balance Changes	Blood Pressure	
Taste Changes	Worst Headache Ever	Difficulty Swallowing	Diabetes	Heart Disease	Epilepsy	
Fibromyalgia	Breast Lumps	Painful Sex	Dizziness / Vertigo	Digestive Problems	Domestic Violence	

LIFESTYLE – WE WANT TO KNOW MORE ABOUT YOUR LIFESTYLE TO UNDERSTAND YOUR PROBLEM (CIRCLE)

Do you Smoke?	Never	Sometimes	Socially	Daily
Do you consume Alcohol?	Never	Socially	1-3x per week	3x + per week
Do you Exercise?	Never	1-2x per week	3-5x per week	5+x per week
Hours of Sleep Per Night?	0- 2	2-4	4-6	6-8	8+
Number of Times You Wake During Night?	0	1	2	3	4	5	6+
Food and Nutrition	Terrible	Could be Better	Good	Best Possible	

CONSENT TO EXAMINATION

I acknowledge I have given accurate information, and it is my responsibility to inform this office of any changes in my health. I agree to a consultation, and examination to see if my case is appropriate for chiropractic care to achieve my health goals. I understand the examination may include spinal palpation, range of motion, posture photo, orthopaedic & neurological testing. If clinically indicated, it may be appropriate to undergo spinal X-ray examination.

FEMALE: Are you pregnant or possibly pregnant? Yes / No

Do you consent to X-ray Examination if clinically indicated? Yes / No

Chiropractic Care is focused on finding and correcting spinal problems that have altered the normal shape and or movement of the spine. Spinal problems may affect function of the nerve system and can be detrimental to your body function health. Chiropractic correct spinal problems using adjustments, forces applied gently to the spine to restore motion, and rehabilitation including exercise, traction devices, shoe lifts, and the like.

CONSENT TO CHIROPRACTIC CARE=

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about. Please carefully read the following:

I acknowledge there are rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, stroke like episodes and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

I do not expect the practitioner to be able to anticipate all the potential risks & complications associated with the proposed care. I acknowledge that if a change in my health/medical history or medication has occurred that I will inform the practitioner as soon as possible, and if I do not, I understand there may be an increased potential risk to treatment.

The goal of chiropractic care is to help your body function better, by improving spinal alignment, spinal joint motion, and nerve function. Your care will aim to increase your movement/flexibility, improve spinal alignment, reduce reactive muscle changes, and change the abnormal input that poor biomechanical function has on your nervous system.

Your care may utilize spinal manual adjustments, drop piece adjustments, instrument adjustments, blocks, exercises, stretches, flexion distraction, posture exercises and spinal traction. I understand that I can withdraw consent at any time. During your care we review progressively, either a monthly basis or every 12 visits, or sooner on indication. Treatment may begin today, or on your next visit.

I hereby acknowledge my consent to the performance of the proposed chiropractic care by Dr. Michael Charlton and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time

NAME: _____

SIGNATURE: _____

DATE: _____

CHIROPRACTOR SIGNATURE: _____