**Welcome to Connective Chiropractic, Dr Bill Logan and Dr Brandon Doyle.**

**Please take the time to complete all three of our initial consultation information forms.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name | | Surname | | | | | |
| Mrs/Miss/Dr/Other | | What do you like to be called? | | | | | |
| Address | | Suburb | | | | | Postcode |
| Email | | | | | (Required for statements/communications) | | |
| Home/Work Phone | | | Mobile | | | | | |
| Date of Birth | Marital Status ☐ Married ☐ Single ☐ Partner ☐ Widowed | | | | | | | |
| Partner’s Name | | | | Children’s names and ages | | | | |
| (cont/d) | | | | | | | | |
| Occupation | | | | | | Employer | | |
| Do you have a Private Health Fund with Chiropractic Cover? ☐Yes ☐No If Yes, Name | | | | | | | | |
| Who may we thank for referring you to our office? | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| When did you last see a chiropractor? | | What was the date of your last spinal x-rays? | |
| Your GP | | Address | |
| List any prescribed medications/drugs you are currently taking | | | |
| (cont/d) | | | |
| **For females only** – Is there a chance you could be pregnant? ☐ Yes ☐No | | | |
|  |  | |  |
| Are you consulting our office for a | ☐Wellness Evaluation | | ☐Specific Heath/Spinal Concern |
|  | | | |

|  |  |  |
| --- | --- | --- |
| Please describe your health/spine concerns below: | |  |
| 1. | | for how long? |
| 2. | | for how long? |
| 3. | | for how long? |
|  |  |  |
| Is your primary objective | ☐Short term relief? | ☐To correct the cause of the symptoms? |

|  |  |  |
| --- | --- | --- |
| **Please tick any of the following symptoms you have experiences at any time in the past 12 months** | | |
| ☐Headache | ☐Breathing problems | ☐Nervousness/Depression |
| ☐Neck pain/stiffness | ☐Asthma | ☐Allergies/Hay fever |
| ☐Dizziness | ☐Digestive problems | ☐Recurrent colds or flu |
| ☐Ringing in the ears | ☐Reproductive Problems | ☐Weight problems |
| ☐Numbness/Tingling in hands | ☐Low Back Pain | ☐Tension and irritability |
| ☐Shoulder tension/pain | ☐Hip Pain (Left or Right) | ☐Menstrual problems |
| ☐Pain between the shoulders | ☐Numbness/Tingling in Legs | ☐Difficulty sleeping |

**IT IS A LEGAL AND SAFETY REQUIREMENT THAT YOU ANSWER ALL OF THE FOLLOWING QUESTIONS**

**It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. Have you experienced any of the following in the past 30 - 90 days?**

* + Unsteadiness of your feet or severe dizziness ☐ Yes ☐ No
  + Difficulty talking or swallowing ☐ Yes ☐ No
  + Unrelenting nausea or vomiting ☐ Yes ☐ No
  + Severe headaches or neck pain unlike ever before ☐ Yes ☐ No
  + Ringing in the ears or recent visual changes ☐ Yes ☐ No

**Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine. Have you experienced any of the following in the past 30 - 90 days?**

* Loss of bowel or bladder control ☐ Yes ☐ No
* Loss of leg muscle size or numbness in the legs ☐ Yes ☐ No
* Difficulty standing or progressive weakness in the legs ☐ Yes ☐ No
* Shooting or sharp pain in the low back or legs when

coughing or sneezing ☐ Yes ☐ No

**General Health History**

* Any history of bone thinning disease such as osteoporosis

or long term corticosteroids? ☐ Yes ☐ No

* Do you have ANY diagnosed health issues? (e.g. diabetes,

asthma, cancer, high blood pressure etc) ☐ Yes ☐ No

* Any recent large loss of weight? ☐ Yes ☐ No
* Have you any implants, surgical clips or foreign bodies

such as pace-makers? ☐ Yes ☐ No

* Do you give permission for us to share your case information

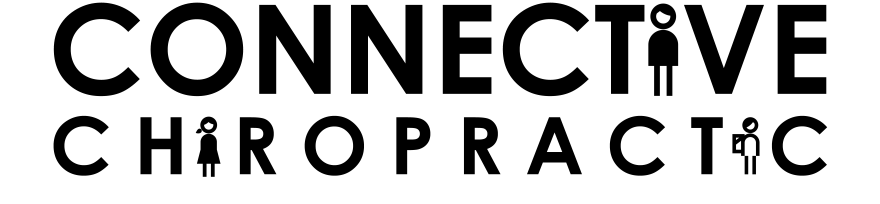
with your immediate family? ☐ Yes ☐ No

**Please note that we do not accept any third party cases such as**

**Workcover or Motor Vehicle Accident Claims.**

**Patient Name**   **Date**

**Patient Signature**

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**INFORMED CONSENT FOR CHIROPRACTIC CARE**

**DR WILLIAM LOGAN**

**When performed by a qualified Chiropractor, spinal manipulation is an effective and safe method of treatment for many conditions. There are however risks associated with any treatment, and Dr Logan is required to inform you of these, even though there has never been a case in this clinic (other than post treatment muscle and joint soreness). Please read the following carefully and write down any questions you may have.**

**Scope of care:** Chiropractic care is focused on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and can be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercises, traction devices, shoe lifts or specifically prescribed orthotic devises to help the spinal corrections.

Chiropractic examinations require palpation of the spine & the pelvic region. It may also require palpation of the sternum and cranial structures including intra oral. There will be a chaperone present during examination & treatment. Private consultation and examination can be requested. Private treatment is available on special request at Rostrevor or at an alternative practice location at Tusmore.

Treatment duration will be assessed and recommended at the initial consultations, and revisited each visit as needed, with further progressive reviews done every 12 visits.

**Medication**: It is common for patients to report changes in medical health conditions. However, changes in medications or management of medical conditions need to be done by your general practitioner or specialist. Chiropractors cannot advise you as to your medical needs.

**Risks of NOT undergoing care:** Spinal problems may get worse if untreated and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and affect general health.

**Risks to patients:** All types of care and examinations have associated risks and it is important that a patient accepts these before undergoing examination and any care including adjustment, exercise and/or traction. Adjustments require forces to move skeletal bones and as such puts stress on blood vessels, bones, discs, nerves and soft tissue. The below are some of the more serious risks but it is not an exhaustive list:

A) **RARE BUT SERIOUS RISKS:** Damage to blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury

B) **MORE COMMON BUT LESS SERIOUS RISKS:** Sprains, strains, rib fractures, bruising inflammation and soreness.

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I (the undersigned) do not expect the doctor to be able to anticipate and explain all the risks and complications. I (the undersigned) also understand that results are not guaranteed.

**Consent for x-rays**: x-rays are taken when indicated to access spinal biomechanics and the integrity of osseous and soft tissue structures.

**Females only - Pregnancy Release:** x-rays can be hazardous to an unborn child. In signing below I consent to x-ray evaluation and certify that to the best of my knowledge I am not pregnant.

In signing below I acknowledge that I have been given opportunity to ask further questions about the spinal examination and spinal x-rays. I also intend this consent form to cover the entire course of treatment for my present condition, and for any other future condition(s).This consent can be withdrawn at any time.

**I, the undersigned, hereby consent to chiropractic x-rays if required and chiropractic treatment by Dr William Logan, and/or any other chiropractor working in this clinic authorised by Dr William Logan for myself or the minor/dependant stated below.**

Patient name: Signature:

***If applicable -*** Carer’s Name: Carer’s Signature:

Dr William Logan signature: Date: / /