HANDS ON CHIROPRACTIC & Health

Centre Pty Limited
ABN 75 850 508 159

Yong Sung Choi B.Med.Sci(Sydney), M. Chiro(Macquarie)

Glenelg Clinic: 54 Pier Street, Glenelg South SA 5045
Stepney Clinic:1/57 Magill Road, Stepney SA 5069
Provider No : 4247666L (Glenelg), 4247665B (Stepney)
Tel: 0430 477 894
Email: handsonchirohealth@gmail.com

Consent To Chiropractic Care

Chiropractic care is recognised as being effective and safe for many conditions. However, you must recognise that there are risks associated with all health and medical care procedures.

Please read the following carefully:

- I acknowledge that I am aware that there are potential risks associated with Chiropractic Care. I do not expect the practitioner to be able to anticipate all potential risks and complications.

- Although they are rare, they include but are not limited to muscle and joint soreness, strains, sprains, nausea and dizziness, disc injuries, fractures, stroke-like episodes or strokes and exacerbation and/or aggravation of my underlying condition.
(The estimated risk for worsening of a pre-existing disc pathology is 1 in 62,000 in the lower back and 1 in 139,000 in the neck. The estimated risk for causing a cerebrovascular accident or severe stroke is 1 in 2 million to 1 in 5.85 million).
In other words, the risk of getting to and from the clinic, travelling, is greater than suffering an injury while under our care.

- I appreciate that results are not guaranteed.

- I Hereby acknowledge my consent to the performance of the proposed Chiropractic care by Yong Sung Choi and/or any other chiropractor working in this clinic.

- If I have any questions or concerns, I will discuss them with the chiropractor.

- I understand that I can withdraw consent at any time.

.....
Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

..... Date: .....
Patient's Name

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Dear Patient

Welcome to Hands On Chiropractic Clinic

We assure you we will try our very best to help you with your condition or concern you may have. We adhere to the strict code of ethics, attend regular continual professional development programs to update our knowledge and keep abreast of new developments. All information given is absolutely confidential.

Date:……/……/……

Name: …….. D.O.B:……/……/……..

Address: …….. Telephone (H): ……

…… Telephone (M): ……

Occupation: …….. Email: ……

Employer: ……

Have you had Chiropractic care before yes / no?

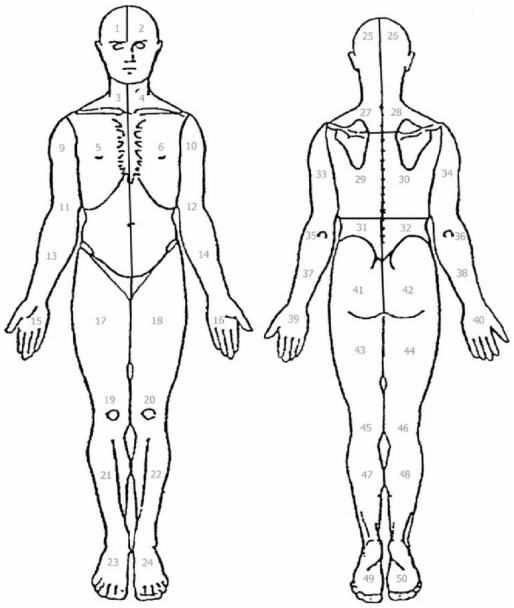
If yes, where: Dr…… in 20……

Have you been recommended/referred to this clinic? By? ……
(a friend, a family member, your GP, walked in off the street, looked up on the internet, Other)

Are you in a Health Fund? Name of fund? ……

Is this a Workcover, Motor Vehicle Accident or other Insurance case?
……

- What is your main area of complaint? please Circle in the picture on the Right.



- **How long has the condition been present for**
……..hours ……..days ……..weeks
……..months ……..years

- **Please describe the symptoms (Circle)**
pain, ache, soreness, stiffness, numbness, burning, pinching, other…….

- **How did it start (Circle)**
suddenly, gradually, after injury /accident, lifting, bending, after illness, woke up with, other ……..

- **How frequent is it? (Circle)**: Constant (100%), Frequent (>50%), Occasionally (25%-49%), Intermittent (<25%)

- **What makes it WORSE/brings on the symptoms (Circle, specify if possible)**
sitting, getting up, standing, walking, bending, lifting, twisting, coughing/sneezing, getting up in morning, lying on back, front, side – left/right, lack of sleep, stress, other ……..

- **What make it BETTER/ alleviates (Circle, specify if possible)**
resting(lying down, sitting), standing, walking, moving around, exercise, heat, ice, massage, medication, other ……

- **How would you rate your pain**
(1 no real pain, 5 marked, 7 severe, 10 unbearable) 1 2 3 4 5 6 7 8 9 10

- **How would you rate your disability**
(1 not impaired doing usual things, 5 only with difficulty, 10 cannot function) 1 2 3 4 5 6 7 8 9 10

- **Have you ever been involved in any Motor Vehicle, Bike or other major Accident/s?**
When…….. Injuries……..

-**Have you ever had any Sports or Work Accidents or Injuries?**
When…….. Injuries……..

-Have you ever had any important illnesses?
(disorder of the heart and circulation (strokes, infarcts), lungs and respiration, stomach and digestion, colon, kidney, bladder, Thyroid, diabetes, uterus/ovaries, prostate, cancer etc)
When…….. What……..

- Have you every had any Operations?
When…….. What……..

- Do you take any medications, vitamins, supplement or similar at present?
What ……..

- **Do you participate in a regular exercise program, sporting activity?**
What……. How often ……..

- Is there anything else you are concerned about?

……..