- Chiropractic
- Myotherapy
- Exercise Physiology
- Podiatry
- Psychology
- Dietetics

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Patient Information Sheet

Personal Details

Mr Ms Mrs Miss **(Circle)** Surname: _____ First Name: _____

Address: _____Suburb:_____P/Code:_____

Phone: (H) _____ (Mobile/Work) _____ Occupation: _____

Email: _____ DOB: / /

Do you have Private Health Insurance: YES NO If yes which fund:_____

Local GP name: _____ Phone number: _____

If TAC, WorkCover or DVA, please complete the following:

Claim/ VA number: _____ Insurer: _____

Date of injury: _____ Employer: _____

Employer's address: _____

Telephone number: _____ Contact: _____

Who referred you to this centre (Please tick)?

GP/ MD	☐	Internet / website/ Google	☐
Other Health Professional _____	☐	Sign	☐
Local Business/ Sports Club/ Gym	☐	Newspaper / advertisement	☐
Friend/ Family: _____	☐	Private Health Fund _____	☐
Yellow Pages	☐	Other _____	☐

Medical history questionnaire

Please tick the following conditions from which you have either suffered from or have noticed recently:

__Dizziness/ Vertigo	___Slurred Speech	___Osteoporosis	___Tingling in arms/legs
__Blurred Vision	___Heart Disease	___Fainting Spells	___Arthritis/Painful Bones/Joints
__Diabetes	___Epilepsy/ seizures	___Cancer	___Weakness in Arms/Legs
__HIV/ AIDS	___Allergies	___ Anemia	___High Blood Pressure/Cholesterol
__Difficulty Breathing	___Chest pain	___ Fatigue	___Bowel or Bladder Problems
__ Nausea/ Vomiting	___Stroke	___ Ulcer	___Night Pain/ Sleeping Problems
__ Hearing impairment	___ Gout	___ Gallbladder disorder	___ Food Sensitivity/ Intolerance
__ Chewing difficulties	___ Eating disorder	___ Obesity	___ Alcohol/ Substance Abuse

Do you exercise? YES NO If YES type & freq/wk: _____

Have you ever had manipulative treatment? YES NO If YES did you have any complications?_____

Do you have a pacemaker? YES NO

Do/ did you smoke? YES NO _____

Are you pregnant? (Females only) YES NO

Are you on the contraceptive pill? (Females) YES NO

Do you take anti-coagulants/blood thinners? YES NO _____

Do/ did you take corticosteroid medication? YES NO _____

Please list any other medications, vitamins or supplements you are taking and why:

_____

PTO

Please list any accidents, fractures, injuries or falls, including car accidents, work injuries or sports injuries:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Please list any surgeries you have had and when:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

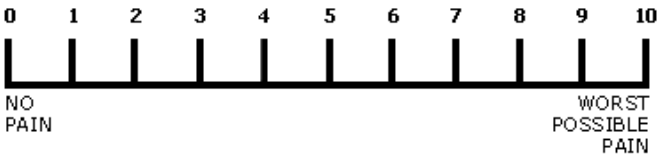
Please list any X-rays, CT scans, MRI's or any other diagnostic tests you have had done:

Type _____ Date _____

Type _____ Date _____

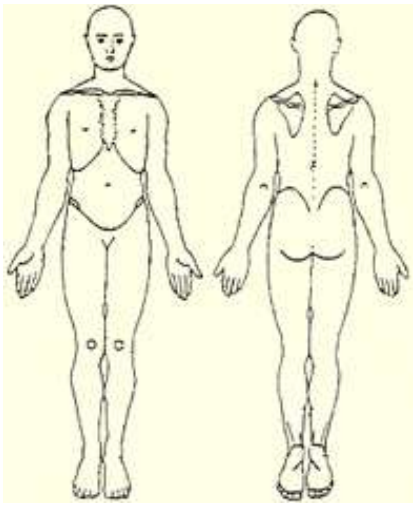
Type _____ Date _____

Please circle on the scale your degree of pain

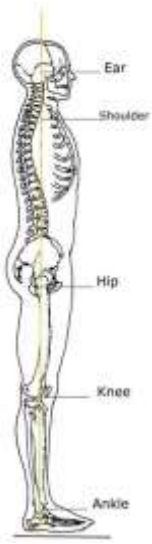


Please tick your main health goal in visiting the clinic to help us form a treatment plan:

- Acute/ pain relief care ☐
- Corrective/ rehabilitative care ☐
- Wellness/ maintenance care ☐



Please colour in areas of discomfort



Informed Consent

When employed skilfully and appropriately chiropractic, exercise physiology, podiatry, dry needling, myotherapy, remedial massage & dietetics care is safe and effective for the prevention and management of many musculoskeletal & health conditions. The aim of the treatment is always to improve the patient's health, however, a patient should before undergoing a treatment understand the relevant factors in relation to it, as there are risks associated with any treatment, Medical or physical therapy. These risks include:

1. In a minority of cases the treatment may not be successful and I may be in the same position as I am now.
2. In the case of treatment with adjustment or manipulation to the spine and pelvis, temporary muscle and joint soreness may occur in some patients.
3. There are rare risks including, but not limited to, sprains and strains to the muscles and ligaments, nausea and dizziness, fractures, disc injuries, and an exacerbation and/or aggravation of my underlying condition.
4. In the case of neck manipulation there have been reported cases of injury to the carotid and vertebral arteries (conservatively estimated at 1:100,000 to 1:400,000). These injuries have been known to cause stroke and stroke-like episodes.
5. In the case of treatment with dry needling there may be temporary aggravation of the symptoms being treated, post needle soreness, slight bruising and fatigue. In extremely rare cases thoracic and chest dry needling may cause a pneumothorax.
6. Therapeutic equipment (i.e. TENS, ICT and Ultrasound) may have harmful effects in rare circumstances.

I acknowledge that I am aware of and understand the potential risks.

I hereby acknowledge my consent for the Body to Balance practitioner treating my condition to the performance of the proposed chiropractic, remedial massage, exercise physiology, podiatry, dry needling, dietetics and/or myotherapy care for my present condition, and for any other future condition(s) for which I seek treatment. I understand that I can withdraw consent at any time.

I authorise where necessary for my treating allied health practitioner to share my medical information with other health professionals or third parties.

We require all accounts to be paid on the day of service. If your private health fund is down or your card does not swipe you are required to pay the full account and claim it manually through your insurer. To claim health insurance rebates and pay online instantly download "HICAPS Go" on your smart phone from the App Store or Google Play.

CANCELLATION POLICY

Please note, any non-attended appointment without notification or cancelled appointments without 24 hours notice may result in the patient being billed 50% of the consultation fee. Consideration will be given for unavoidable circumstances. We would appreciate 24 hours notice when re-scheduling your appointment. Thank you for your co-operation.

Signed: _____ *Date* / /