Ginninderra Chiropractic

Unit 2, Palmerston Shops, Palmerston ACT 2913 p 6241 0447

Welcome! We Thank You for Your Trust!

Tell us about You.

1. Full Name (Last, First, Middle):
____
2. Full Address (Street, Suburb, State, Post Code):
____
____
____
3. Telephone: Home ____________________
Mobile ____________________
Work____________________
4. Email ______________________________

5. Occupation: _________________________
6. Employer:___________________________

7. Date of Birth: _______________________
8. How young are you? __________________

9. Private Health Fund: __________________

10. ___ Male ___ Female
___ Married ___ Single

11. Spouse's Name: ____________________
12. Number of Children: ________________

13. Is it possible you are pregnant?
___ Yes ___ No

14. Whom may we thank for referring you?
____

15. Are you here due to:
___ on the job injury
___ vehicle accident ___ slip or fall
___ health problem ___ wellness care

Emergency Contact:
Name____________________________Relationship_____________________Phone ________________

Reason for Care.

1. Why are you seeking care? ____

2. When did the problem start? ____

3. Have you had this problem before?: ___ Yes ___ No, if "Yes", when ___________________________

4. Is the problem (tick all that apply): ___ constant ___ intermittent ___ numbness ___ pins and needles

___ dull ache ___ sharp ___ burning ___ radiating ___ localized ___ better in the a.m ___ better in the p.m ___ better while active ___ better while sitting ___ better while laying down

5. Describe any other health problems ____

____

6. Have you ever been to a Chiropractor before? ___ Yes ___ No, If yes, when were you there last? ____
7. List current medications: ____
8. List past surgeries and dates: ____
9. List past accidents and dates: ____
____

PLEASE SIGN:_____________________ **DATE** ___________________
(Parent should sign for minor child)

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CONSENT FORM

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 read the following carefully:-

1. I acknowledge that I have discussed with **Jenny Roppola** the 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, strokes (or 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.
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

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………

3. I have had the opportunity to discuss the proposed care with **Jenny Roppola**. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by **Jenny Roppola** and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.
7. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** eg between 1 in 2 million to 1 in 5.85 million - Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (**current statistics** eg less than 1 in 139,000) and the low back (**current statistics** eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."*

<u>Financial Policy</u>

1. Payment is required at the time of consultation. We do not keep accounts.
2. Cancellation or rescheduling must be made 24 hours in advance or a fee will apply.
3. If you fail to show up for a scheduled appointment, you will be billed the full amount.

……………………………………………………

Patient's Signature

(Parent or Guardian to also sign if patient is under 18)

……………………………………………………

Patient's Name (printed)

………………………………………………

Chiropractor's Signature

Dated:………………………