Vital Family Chiropractic

Dear Visitor, your chiropractor is not a medic. Your care will not be based on symptoms or diagnosed conditions. Your case will be accepted if vertebral subluxations are present.

A body free of vertebral subluxations functions better at every level.

Please complete this questionnaire. Your answers will help establish how chiropractic will help you.

If we are not firmly convinced to be of assistance we will not accept your case.

First Name:	Surname:	Birthdate:
Street:	Suburb:	Post code:
Home Phone:	Work Phone:	Mobile:
Names and Ages of Spouse and Children	Spouse:	Children:
Email:	Occupation: Previous:	Is this a worker's compensation, third party or department of veteran affairs claim?: Yes / No

What brings you to a chiropractor? Wellness check-up? ☐ or

Main concern: _____ since/how long? _____

Have you had **similar problems** in the past? _____

What was the **previous treatment and results?** _____

List other **health issues /injuries you would like to improve:**

1. _____ Since/ how long? _____

2. _____ Since/ how long? _____

3. _____ Since/ how long? _____

Diagnosed Illnesses; what and when: _____

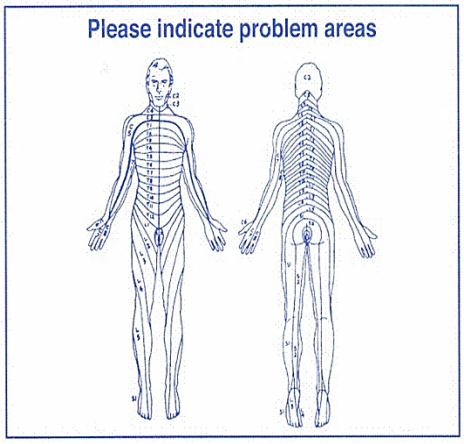
Please list any **operations** you have had and when: _____

What **conditions** are you currently taking medication for? _____

_____ **Are you pregnant?** Yes/ No

Please tick the following symptoms that you have experienced in the last 6 months

□Lower back pain	□Tension across the shoulders	□Nervous
□Pain between the shoulders	□Pins or needles in arms or legs	□Difficulty sleeping
□Neck pain	□Dizziness	□Allergies
□Migraine Headaches	□Ringing in ears	□Digestive problems
□Tired / Fatigued	□Tension headaches	□Weight trouble



Have you ever had a serious car accident, fall or sports injury?

Details: _____

_____

Have you seen a Chiropractor before? YES / NO

Name of Chiropractor?

_____

What were you being adjusted for? _____

How many visits? _____ When was your last visit? _____

How would you rate your experience?

□Excellent □Satisfactory □Unsatisfactory

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Informed Consent

Chiropractic is recognised as being an **effective and safe form of healing**. In fact, due to the wonderful results, chiropractic is the largest drug-free health care profession in the world.

Due to recent major world events and changes in the health and insurance industries, we want to inform you of the possible risks associated with chiropractic care.

1. You will be tested before any adjustments are applied;
2. Very rare risks may include muscle soreness, strain to a ligament or disc in the neck or lower back, and aggravation of underlying condition;
3. Extremely rare is the risk of damage to neck blood vessels, which can arise in stroke or like symptoms.
4. Chiropractic adjustments of the spine are internationally recognised as being far safer than medication and many other alternatives (see below).

I, (First and Last Name) _____ acknowledge the above information and do not expect the Chiropractor to be able to anticipate all potential risks and complications. Based on all the information provided, **I consent to any further recommended testing, including x-ray films of my spine. I agree to return for my report of chiropractic findings and review my spinal x-rays.** If chiropractic care is recommended based on the report of findings I look forward to receiving chiropractic care at this office.

Patient Signature _____ **Date / /**

Parent/Guardian Signature _____ **Date / /**

Dr Mario Stefano
CHIROPRACTOR _____ **Date / /**

Chiropractic care	
Cervical Spine (Neck)	
(Temporary) Radiculopathy associated with disc injury	1:139,000
Vascular Injury	1:5.85 Million
Lumbar Spine	
Disc injury with radiating pain	1:62,000
Radiculopathy	1:188,000
Cauna equine syndrome	1:656,000
In Comparison	
Hospitalisation for gastrointestinal Bleeding (NSAID) (following one month of medication)	1:250
Deaths associated with NSAID's (US)	3200p.a
(AUS)	360p.a
Death from general anaesthetic	1:1250
Death from Cancer (all kinds)	1:555
Injury from Motor Vehicle Accident	1:93,000
Hospitalisation for adverse drug reactions	20,000 to 26,000 pa

Privacy Act 1988 (Commonwealth)

This Chiropractic Office complies with the above act; Information provided by you is collected with a view to helping you with your health concerns. It is not used or disclosed to any third parties or organisations, other than required by our professional advisors (e.g. insurers) or required by law.

To keep you abreast of news, developments and activities at our office, you will be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities etc. Additionally, we may contact you in relation to your care. We require your permission to contact you, either by post, fax, email, telephone or otherwise.

Patient Signature_____**Date:** _____