Welcome!

1st visit - Initial Consultation & Examination – 30 minutes

At Bayside Family Chiropractic, we take health seriously. Dr Sean will give you the opportunity to discuss your health concerns thoroughly before moving onto the comprehensive physical examination. Regularly, people say this is the most thorough exam they have ever had anywhere. The physical exam will address, neurological, spinal, postural, orthopaedic and musculoskeletal assessments. If imaging is required, we will refer out to the local provider.

Dr Sean may or may not give any treatment on this initial visit. This will depend on the outcomes of the initial examination and if further studies are required. Making the correct decisions about your health is important to both Dr Sean and you. All your examination results require thorough analysis and a detailed report is given on the following visit.

2nd visit – Report of Findings – 30 minutes

Dr Sean will review your results and clinical findings found during your initial consultation and will let you know if and how he can help you. Dr Sean will provide you with advice and different options to achieve your desired health goals and you can then make an informed choice what is best for you. If you are happy with the solution you will receive your first adjustment on your path to better health. If chiropractic isn't the best option for you at this time he will let you know and refer you to the appropriate practitioners.

We look forward to helping you to achieve your health goals!

3/5 Town Centre Circuit, Salamander Bay NSW 2317

(02) 4984 6897 reception@baysidefamilychiropractic.com.au

BAYSIDE FAMILY CHIROPRACTIC

Why live an ordinary life when it can be EXTRAORDINARY?

Dr Sean Mahony (DC) _____

CONFIDENTIAL PATIENT INFORMATION

Full name:	**Date:**
Address:	
Best Contact Number:	**Secondary Contact Number:**
Email:	**Tick this box if you DO NOT wish to receive our updates/emails: □**
Date of birth:	**Gender:**
Health Care Fund Name:	**Dr:**
Next of Kin - Name:	**Your Occupation:**
Next of Kin – Number:	**No. of children:**
Next of Kin – Relationship:	**Who or what referred you to our clinic?**

Have you had previous Chiropractic care? Yes/No_____

Name of previous Chiropractor: _____

Where were they located? _____

When was your last adjustment? _____

What is your reason for today's visit? _____

_____

_____

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BAYSIDE
FAMILY CHIROPRACTIC

Please tick if you have had, or now have any of the following:

□	History of Cancer/family history of Cancer	□	Unexplained weight loss
□	Accidents or injury	□	Fractures
□	Hospitalisations	□	Operations
□	Systematically unwell	□	Bilateral pins and needles
□	Trauma eg fall, accident or sporting	□	Pregnancy/ies
□	Cardio Vascular Disease	□	Osteoporosis /bone disease
□	Diabetes	□	Depression / Anxiety / Nervousness
□	Asthma	□	Epilepsy
□	Headache / Migraines	□	Multiple Sclerosis
□	Ringing in the ears	□	Sinus problems
□	Stroke	□	Substance abuse / addictions
		□	Other

I have pain or another symptom. (Please describe)

_____

_____

_____

List any surgical operations and year they were performed:

_____

_____

List any medications/supplements you now take:

_____

_____

Have you been in a motor car accident: If yes, when?

_____

_____

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BAYSIDE FAMILY CHIROPRACTIC

Functional Rating Index

For use with **neck and / or back problems** only. In order to properly assess your condition, we must understand how much your **neck and / or back problems** have affected your ability to manage everyday activities. For each item below, please circle **the number which most closely describes your condition right now**

Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Sleeping

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Personal Care (washing dressing, etc)

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Travel

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Work

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Recreation

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Frequency of all pain

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Lifting

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Walking

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Standing

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Name _____ Signature _____ Date / / _____ Total Score _____

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CONSENT FORM FOR CHIROPRACTIC CARE

We require all patients to acknowledge their understanding of the potential risks, however small, associated with chiropractic care.

Any health care intervention attracts some risk and the chiropractic profession is proud of the safe track record we have maintained over more than 100 years of service.

We have listed some significant risks below with a comparison to some common medical risks to put the issue into some perspective.

Chiropractic Care		Medical/Other	
Temporary discomfort after Chiropractic adjustment	1/50 (estimate)	Stomach bleedings from anti-inflammatories after 1 month	1/250
Lumbar disk injury	1/62,000	Death from anti-inflammatories	360/year
Cervical neck injury	1/139,000	Death from general anesthetic	1/1,250
Lumbar nerve injury	1/188,000	Injury from car accident	1/9,300
Loss of consciousness & spinal cord damage	1/382,000	Death from lightning strike	1/20,000
Death from stroke	1/5.8 million		

As you can see, chiropractic involves very safe procedures. Once you feel you understand the risk involved and if, after consideration you would like to commence or continue your chiropractic care, could you please write your name clearly below, date, and sign in the space provided.

Any of our staff are happy to discuss this further with you.

NAME OF PATIENT (BLOCK LETTERS) _____

SIGNED_____ (GUARDIAN FOR PATIENT UNDER 18)

DATE ___/____/___

CHIROPRACTOR Dr Sean Mahony SIGNED_____ DATE ___/____/___

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