BAYSIDE FAMILY CHIROPRACTIC

Scanned □ Entered □ Perfect Patients □

Intake form - Massage

Full name:	**Date:**
Address: Street City State Post Code	
Best Contact Number:	**Secondary Contact Number:**
Email:	**Tick this box if you DO NOT wish to receive our updates/emails: □**
Date of birth:	**Age:**
Occupation:	**Spouse/guardian name and number:**
Health Fund Name:	**Dr:**

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

Recreation				
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

Frequency of all pain				
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

Lifting				
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

Walking				
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

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

Total Score	

BAYSIDE
FAMILY CHIROPRACTIC

How did you hear about us?

□ Google	□ Facebook	□ Instagram	□ Local Directories	□ Driving Past	□ Voucher
□ Word of mouth. Who?	□ What's on in our backyard	□ Anytime Fitness	□ Curves	□ iGym	□ Other

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

□ Alcoholism	□ Allergy	□ Anaemia	□ Anxiety	□ Arthritis	□ Asthma
□ Blood Clots	□ Blood Pressure	□ Cancer	□ Constipation / Diarrhoea	□ Dental / Jaw Problems	□ Depression
□ Diabetes	□ Diseases / Infectious	□ Eczema	□ Emphysema	□ Epilepsy	□ Fatigue
□ Hernia	□ Headaches	□ Heart Attack	□ Heart Disease	□ Hormonal Problems	□ Injuries
□ Low Blood Sugar	□ Jaw Problems	□ Joint Problems	□ Mental Health	□ Migraines	□ Muscle Problems
□ Nervousness	□ Numbness / Tingling	□ Pregnant	□ Sprains / Strains	□ Sinus	□ Stress
□ Stroke	□ Tinnitus	□ Thyroid Problems	□ Ulcers	□ Varicose Veins	□ Other not listed

Others not listed / more details

_____

What is your primary reason for an appointment today? What can we help you with?

_____

Have you had experience with massage before?

_____

Are you currently taking any medication, including aspirin, ibuprofen, herbs or supplements?

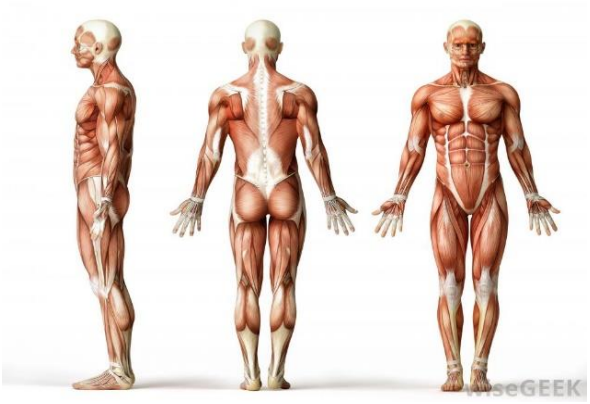
_____

Please list all forms and frequency of activities, hobbies, exercise or sports participation.

_____

Have you had any accidents or injuries? If so what and when?

_____



CANCELLATION POLICY

With respect to other clients, we request 24 hours' notice should you need to reschedule or cancel your appointment. We have specifically kept your appointment for you. Cancellation fees will apply should appropriate notice not be given. Cancel or reschedule with less than 4 hours' notice: 50% booked appointment fee - if we cannot fill the appointment. Missed appointment: 100% cancellation fee. Late arrivals will result in an abbreviated appointment.

Please highlight your areas of concern.

Massage and/or Dry Needling Consent

I understand that the massage I receive is for the purpose of stress reduction and relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the massage practitioner so that the pressure or methods can be adjusted to my comfort level. I understand that massage professionals do not diagnose illness or disease or perform and spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the session can be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I should see a health care provider for those services. Because massage should not be performed under certain circumstances, I agree to keep the massage practitioner updated as to any changes in my health profile, and I release the massage professional from any liability if I fail to do so.

Signature _____ **Print Name**_____ **Date** ____/____/____

By my signature I authorise Bayside Family Chiropractic to provide remedial massage to my child or dependent.

Signature of Parent or Guardian_____

Please read below and sign if you are having Dry needling.

What is Dry Needling?

Dry Needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry Needling is not acupuncture; in fact, it is modern intervention treatment of pain and dysfunction in musculoskeletal conditions: neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

What are the risks with dry needling?

The possible risks and adverse reactions to Dry Needling therapy include but are not limited to temporary pain, bleeding, bruising, infection, dizziness, nerve injury, pneumothorax, pregnancy termination, changes to blood pressure, rash, fainting, muscle soreness &fatigue. Serious Adverse Events (AE's) Pneumothorax, Cardiac Tamponade & damage to organs (0.04%). Mild or moderate AEs included bruising (7.55%), bleeding (4.65%), pain during treatment (3.01%), and pain after treatment (2.19%). Uncommon AEs include aggravation of symptoms (0.88%), drowsiness (0.26%), headache (0.14%), and nausea (0.13%). Rare AEs fatigue (0.04%), altered emotions (0.04%), shaking, itching, claustrophobia, and numbness, all 0.01%. Brady, S et al. Journal of Manual and Manipulative Therapy 2013 VOL. 000 NO. 000 (2013)

Please tick below if you have had any of the following.

Spontaneous bleeding or bruising		Irregular heart beat	
Tendency to bleed – taking anti-coagulant therapy		Previous adverse reaction to acupuncture or dry needling therapy	
Seizure induced by previous medical procedure		Compromised immune system	
Unstable diabetes		Unstable angina	
Congenital or acquired heart valve disease		Recent cardiac surgery or congestive cardiac failure	
Recent radiotherapy		Allergy to Nickel or Chromium	
Malignancy		Haematoma	
Cosmetic or surgical implants		Eczema or psoriasis	
Peripheral neuropathy		Recurrent infections	
Open skin wounds or injuries		Stable or unstable or schizophrenia	
Chronic oedema or Lymphoedema		Pacemaker or any other electrical implants	
		Acute cardiac arrhythmia's	

STATEMENT OF CONSENT- I confirm that I have read and understand the above information, and I consent to having Dry Needling treatments. I understand that I can refuse treatment at any time.

Signature _____ **Print Name**_____ **Date** ____/____/____