PATIENT INTAKE FORM

Thank you for taking the time to fill this form and provide us with details of your health

PERSONAL INFORMATION

FIRST NAME:

D.O.B.

LAST NAME:

DO YOU HAVE CHILDREN:

GENDER: O MALE O FEMALE O NB O OTHER

OCCUPATION:

CONTACT INFORMATION

D.O.B:

HOME ADDRESS:

PHONE NUMBER:

CITY:

EMAIL:

POSTCODE:

WHO MAY WE THANK FOR REFERRING YOU TO CASA WELLBEING TODAY?

HEALTH INFORMATION

HAVE YOU PREVIOUSLY EXPERIENCED CHIROPRACTIC CARE? O YES O NO

WHAT WOULD YOU MOST LIKE TO GET OUT OF YOUR CARE TODAY? *Eg. to feel or be able to do?*

ARE YOU SEEKING THE SUPPORT OF ANY OTHER HEALTH CARE PRACTITIONERS? *If so what / who?*
O YES O NO

ARE YOU TAKING ANY HERBAL OR NUTRITIONAL SUPPLEMENTS? *If so what and how much?*
O YES O NO

ARE YOU TAKING ANY MEDICATION? *If so what and how much?*
O YES O NO

DO YOU SUFFER FROM ANY CONDITIONS? *Eg: diabetes, high/low blood pressure, headaches, asthma etc.*
O YES O NO

DOES YOUR BODY EXPERIENCE ANY ISSUES WITH ... *tick or circle*

- O Constipation / loose bowels / reflux / bloating
- O Sinus - asthma / COPD
- O Frequently unwell / tonsils / inner ear / lymph nodes
- O Fatty liver / difficult eating fatty foods / gall stones
- O Sugar imbalance / cravings
- O Joint or muscle pain - arthritis / posture / cramps / fibromyalgia
- O Hormonal regulation / thyroid / adrenals / reproduction / prostate
- O Mental health - anxiety / depression / PTSD
- O Neuromental-development - ADD / ASD / OCD / tourettes / dyslexia
- O Hair/Skin/Nail issues - pimples / acne / psoriasis / eczema / alopecia
- O Frequent urination or pain / kidney stones / wake to urinate / pelvic floor
- O Other:

PHYSICAL

WHAT DOES YOUR BODY DO REGULARLY? O SIT O DRIVE O CROSS LEGS O LIFTING O OTHER:

HOW DO YOU MOVE YOUR BODY? *Eg: run, cycle, walk, sport, gym etc. If so what and how often?*

HAVE YOU HAD ANY SIGNIFICANT FALLS OR ACCIDENTS IN YOUR LIFE? *If so what and when.*
O YES O NO

HAVE YOU UNDERGONE ANY SURGERIES? *Eg: wisdom teeth removal, bone break etc. If so what and when.*
O YES O NO

CHEMICAL

HOW MANY HOURS OF SLEEP DO YOU GET A NIGHT?

DO YOU HAVE ANY DISRUPTIONS TO YOUR SLEEP? *Eg. difficulty falling or staying asleep, waking at certain time etc.*

DO YOU HAVE ANY FOOD SENSITIVITIES *If other, please specify*
O NO O GLUTEN O DAIRY O EGGS O NUTS O SUGAR O OTHER

HOW OFTEN DO YOU CONSUME:

CAFFEINE: *eg. tea, coffee, energy drinks etc.* /day /week /month

ALCOHOL: /day /week /month

CIGARETTES / VAPE: /day /week /month

WATER: O 1 ltr/day O 1.5 ltr/day O 2 ltr/day O 2.5 ltr/day O 5 ltr/day O Other

HAVE YOU PREVIOUSLY HAD ANY MAJOR ILLNESSES? *Eg: influenza, glandular, cancer etc. If so what and when.*
O YES O NO

HAVE YOU BEEN EXPOSED TO ANY MAJOR TOXINS? *Eg: amalgam fillings, chemicals, metals etc. If so what and when.*
O YES O NO

HAVE YOU EVER TAKEN ANTIBIOTICS?
O NEVER O RARELY O YES RECENTLY O YES OVER A YEAR AGO

EMOTIONAL

HAVE YOU EVER BEEN EFFECTED BY TRAUMA? *Eg: bullying, divorce, isolation, abuse, DV, hardship etc. If so what?*
O YES O NO

WOULD YOU SAY YOUR EFFECTED BY STRESS EASILY? *If so how often?* O NO O RARELY O OFTEN O DAILY

WHAT IS THE BIGGEST CONTRIBUTOR TO STRESS?

"We become what we regularly do, regularly think and regularly eat."

PATIENT CONSENT TO CHIROPRACTIC CARE

Chiropractic care has a *very low risk profile*, especially when compared with more invasive methods of spinal healthcare however, all forms of chiropractic treatment have the potential for adverse reactions in some people.

- I acknowledge that I have discussed with Dr. Luke Oswald 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.
- I have had the opportunity to discuss the proposed care with Dr. Luke Oswald. 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
- I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed
- I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care
- I hereby acknowledge my consent to the performance of the proposed chiropractic care by Dr. Luke Oswald and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time
- 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.

PATIENT NAME ....
(please print)

SIGNATURE .... DATE ....
(Parent/Guardian to also sign if under 18yo)

CHIROPRACTOR SIGNATURE ....
(practice use only)

Thank you!