

## Welcome to Body & Brain Centre!

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Suburb:** \_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Hobbies:** \_\_\_\_\_

Please Tick:  I would like to receive newsletters with special offers, health tips and more.

**Emergency Contact - Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **R'ship:** \_\_\_\_\_

**Children Names & Ages:** \_\_\_\_\_

**Could you be pregnant?**  No  Trying  Yes: \_\_\_ weeks **Are you breastfeeding?**  Yes  No

**Who can we thank for referring you?** \_\_\_\_\_ PS they will get a thank-you voucher

**If online, what search words were used?** \_\_\_\_\_

**Have you had chiropractic care previously?** Yes / No **Last Treatment:** \_\_\_\_\_

**Name of Previous Chiropractor:** \_\_\_\_\_

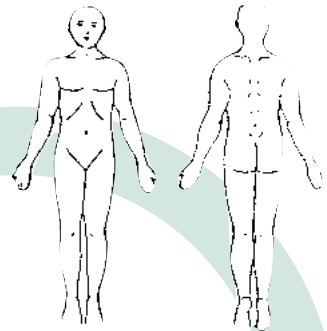
**Techniques your chiropractor used?**  Manual Adjustments  Rehabilitation Exercises  Drop Piece  Massage  Blocks / Wedges  Activator / Instrument  Other \_\_\_\_\_

**Please describe your present condition/s, how it started & mark on the diagram (if relevant):**

Condition 1: \_\_\_\_\_

Condition 2: \_\_\_\_\_

Condition 3: \_\_\_\_\_



	<b>When Did it Start?</b> Date or days, months, years	<b>How Often do you Feel it?</b> 0% = never, 100% = always	<b>How Long Does it Last?</b>	<b>Progress:</b> Getting worse? Constant? Improving?	<b>When is it worst?</b> Waking up, night time, after sitting	<b>Pain 0 = no pain, 10 = worst pain</b>
<b>Condition 1</b>						Average: ___ Worst: ___ /10 Best: ___ /10
<b>Condition 2</b>						Average: ___ Worst: ___ /10 Best: ___ /10
<b>Condition 3</b>						Average: ___ Worst: ___ /10 Best: ___ /10

**Physical**

Chiropractic  
Myotherapy  
Remedial Massage

**Brain**

Biofeedback  
Neuro-Rehab  
Brain Scans

**Emotional**

Counselling  
Meditation

**Nutritional**

Dietetics/Nutrition  
Naturopathy

**Traditional**

Acupuncture  
Chinese Medicine

Continue from front...	Improves with ... Medication, ice, heat, movement, rest, nothing	Worse with ... Coughing, sneezing, bending, sitting, inactivity, left rotation, etc
Condition 1		
Condition 2		
Condition 3		

How do you rate your: **General wellbeing** \_\_\_/10 **Why?** \_\_\_\_\_

**Diet** \_\_\_/10  5 vegetables daily  fruit daily  2L water daily  coffee / tea  "junk" food daily

**How do you respond to caffeine?**  Required to function  Sensitive to effects  No change

**How do you feel after a meal?**  Energised  Fatigued  No Change **Alcohol Weekly:** \_\_\_\_\_

**Have you ever smoked?**  Current  Past  Never **How long?** \_\_\_\_\_ **How many daily?** \_\_\_\_\_

**Exercise** \_\_\_/10

**Typical exercise routine:**

Type: \_\_\_\_\_ Intensity / Distance: \_\_\_\_\_ Frequency: \_\_\_\_\_ per week

Type: \_\_\_\_\_ Intensity / Distance: \_\_\_\_\_ Frequency: \_\_\_\_\_ per week

**Sleep** \_\_\_/10  Trouble getting to sleep  Wake up in the night **Awake Feeling:**  Tired  Alert

**What time do you: Go to bed?** \_\_\_\_\_ **Get to sleep?** \_\_\_\_\_ **Wake up?** \_\_\_\_\_

**Stress** \_\_\_/10

**Experience stress:**  Frequently  Sometimes  Rarely

**Biggest Source of Stress:**  Work  Personal  Other \_\_\_\_\_  Everything

**Mood** \_\_\_/10 **Why?** \_\_\_\_\_

**Please list any medication (including supplements, contraception & recreational drugs):**

**Current:** \_\_\_\_\_

**Significant Previous:** \_\_\_\_\_

**Please list any surgeries you've had & when:** Surgery: \_\_\_\_\_ Year: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year: \_\_\_\_\_ Surgery: \_\_\_\_\_ Year: \_\_\_\_\_

**Please Outline Any Accidents You've Had and When:** Include concussions / hits to the head, motor vehicle accidents, falls, broken bones or dislocations

Incidence: \_\_\_\_\_ Year: \_\_\_\_\_ Incidence: \_\_\_\_\_ Year: \_\_\_\_\_

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**Have you suffered any major or recurring conditions?**  Heart attack / disease  Blood clots  
 High / low blood pressure  Fainting  High cholesterol  Skin concerns  Diabetes  Thyroid  
 Hormonal concerns  Gut issues (constipation, diarrhoea, bloating, pain)  Breathing difficulties  
 Cancer  Genetic  Anxiety  Depression  Dementia  Seizures  Learning difficulties  
 Osteoporosis  Arthritis  Muscle cramps / twitches  Loss of muscle strength  
 Serious infections  Any illness in last 3 weeks  Hospitalisation in the last 5 years

**Other / Details:** \_\_\_\_\_

**Allergies / Sensitivities:** \_\_\_\_\_

**Has someone in your Family suffered any major or recurring conditions? Please indicate relationship to you for each condition in your family history. Examples as listed above.**

**Maternal:** \_\_\_\_\_

**Paternal:** \_\_\_\_\_

**Siblings:** \_\_\_\_\_

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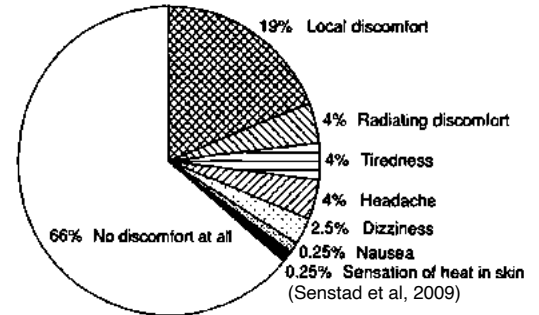
## Informed Consent to Chiropractic Care

Benefits of Chiropractic Care are vast!

- More mobility & less stiffness
- Headaches & migraines
- Dizziness, vertigo & unsteadiness
- Better sporting performance
- Prenatal health: less pain, less drugs, faster deliveries
- Reduced falls
- Sciatica, back pain & neck pain
- Scoliosis
- Sporting injuries
- Arthritis
- Neurological conditions
- Kids health

At Body & Brain, we take an integrative approach using different techniques depending on ***your preference*** & presentation.

1. Physical Examination
2. Manual chiropractic adjustments ("cracking") of the spine, arms & legs
3. Non-cracking joint mobilisations: Activator ("Clicker"), pelvic blocks, cranial therapy, drop piece (the loud table), mobilisations
4. Massage & stretches
5. Rehabilitation & home exercises
6. Taping
7. Cupping
8. Dry needling
9. Electrical stimulation
10. Laser therapy
11. Supplements & lifestyle advice



Hands on therapies are extremely effective in treating pain and dysfunction. After therapy, around a third will pull up with some slight discomfort which generally lasts 24 - 48 hours (see pie chart). In rare circumstances, injuries can occur such as (in descending order of likelihood) bruising, sprains, strains, disc injuries, fractures of weakened bones, infection, pinched spinal cord, collapsed lung or damage to blood vessels. These are more common with manual adjustments & dry needling. Cupping frequently results in desired skin discolouration that lasts days-weeks, but occasionally bruising may also occur.

To achieve the **best results**, it's important to follow your management plan, including individually-formed home exercises plans, activities to avoid, lifestyle modifications, recommended supplements and your treatment schedule.

Reactions to tape, electrodes or massage cream are possible. Do you have any allergies? \_\_\_\_\_

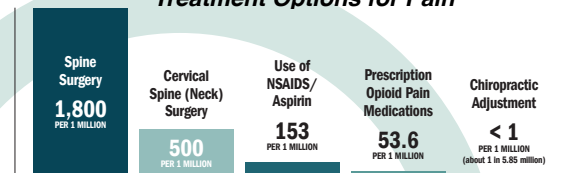
### Other treatment options

Medication, surgery, injections, bracing or rest can also be used to treat your pain & dysfunction. These also carry risks including organ irritation, medication dependence, infection and extended recovery times.

Chiropractic can be used with standard medicare care & when combined, shows significant advantages compared to medical care along.

The risk of remaining untreated or delaying treatment include complicating your condition and make future treatment and rehabilitation programs more complex, timely and expensive.

### Risks of Serious Side Effects with Common Treatment Options for Pain



EDITOR'S NOTE: This graph is reproduced with permission from Palmer College of Chiropractic; available at [www.palmer.edu/gallup-report/sources/02/16/](http://www.palmer.edu/gallup-report/sources/02/16/). It has been reformatted to match our standard layout specifications.

### **PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR CHIROPRACTOR.**

After reading the above and discussing with my chiropractor, I understand the potential risks and that results aren't guaranteed. I don't expect the chiropractor to be able to anticipate or explain all possible risks.

attend my appointment, I will be liable for 100% of the consultation fees. I also understand that all fees are payable on the day of consultation.

### Please Tick

- The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and treatment plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.
- I hereby request and consent to chiropractic examination and management. I understand that I can withdraw my consent at any time.
- I consent to information being sent to third parties when I have authorised it (eg: private health insurance).
- I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancellation fee. If I fail to provide notice that I cannot

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

(Parent/Guardian if under 18 years)

CHIROPRACTOR'S SIGNATURE \_\_\_\_\_

Own behalf of any chiropractor of Body and Brain Centre

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