## 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:** _____

***Congrats on your bubba!!*** **How old is your baby?** _____ **Baby's name**_____
**How many times have you been pregnant?** _____ **How many child do you have?** _____
**How old are any other children?** _____ **Are you breastfeeding?** ❒ Yes ❒ No ❒ Previously

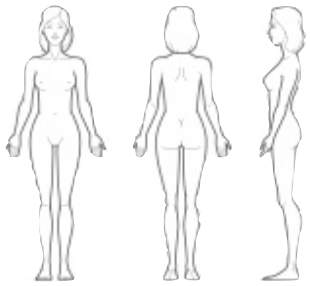
**Who can we thank for referring you?** _____ PS they will get a thank-you voucher

**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?** _____

**Please describe your present condition/s, <u>how</u> it started & mark on the diagram (if relevant):**
Condition 1: _____
_____

Condition 2: _____
_____



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

| | **Improves with** … Medication, ice, heat, movement, rest, nothing | **Worse with** … Coughing, sneezing, bending, sitting, inactivity, left rotation, etc |
|---|---|---|
| **Condition 1** | | |
| **Condition 2** | | |

## General Wellbeing

**How do you rate your general wellbeing** ___/10 **Why?** _____

**Have you ever smoked?** ❒ Current ❒ Past ❒ Never **How long?** ____ **How many daily?**_____

**Typical exercise routine:** _____

**Apart from disrupted sleep from your baby, do you have any sleep issues?** _____

**Mood** ___/10 **Why?** _____

## Preconception Care

**Did you use any assistance to fall pregnant?** _____
**How were you looking after yourself during the preconception time?** _____
_____

## Pregnancy Health

**Did you experience any discomfort including nausea, heartburn, pain or other?**
_____
**Were there any worries or complications?** _____
_____
**How many scans did you have & when?** _____
**Where did you give birth?** _____
**Who was part of your birth & pregnancy support?** ❒ GP ❒ OB ❒ Midwife ❒ Doula

## Previous Pregnancies

**Have there been any difficulties with previous pregnancies?** _____

## Birth

**How long was the labour?** From first contraction until birth _____ **Push time?** _____
**How Many Weeks?** _____ **Birth Weight:** _____
**How was your Child Delivered?** ❒ Vaginal ❒ Caesarian (planned) ❒ Caesarean (emergency)
**How did your Child Present?** ❒ Crown / Top of Head First ❒ Face First ❒ Breach ❒ Other (detail)
**Were any Interventions Used?** ❒ Epidural ❒ Induction ❒ Forceps ❒ Suction ❒ Other (detail)
**Did you Have any Tears or Stitches, including where & degree?** _____
**Details:** _____
**Do you believe the birth process was traumatic?** _____

## Postpartum

**How is your child fed?** ❒ Breastfed ❒ Formula ❒ Expressed breastmilk
**Have you had any issues breastfeeding?** If so, please describe. _____
_____
**How do you feel your body is recovery?** _____

## Health History

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

**Please list any physical trauma:** includes broken bones, hits to the head, vehicle accidents, falls, surgeries
Trauma: _____ Year: _____ Trauma: _____ Year: _____
Trauma: _____ Year: _____ Trauma: _____ Year: _____

**Have you suffered any major or recurring conditions?** eg: stroke, heart, hormones, gut, psychological:
_____
**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.**
_____

**Informed Consent to Chiropractic Care**
Postpartum Chiropractic is adapted as your body changes. Different techniques may be used at different times of your recovery and options will always be given for your comfort.

**Some techniques that may be used might include:**

1. Physical Examination
2. Chiropractic adjustments (manipulations) of the spine or extremities (arms & legs)
3. Low force joint mobilisations
4. Massage and soft tissue techniques
5. Rehabilitation or home exercises
6. Taping
7. Electrical Stimulation
8. Laser
9. Supplements and / or dietary advice

After treatment, some people pull up with some tenderness, tiredness or headache. This tends to occur in a third of people and lasts 1-2 days. Some people experience stiffness, dizziness or nausea. If manual adjustments are used, there's a very small chance of fractures to weakened bones (eg: osteoporosis), cervical myelopathy (spinal cord being pinched in the neck), strain / sprain injuries, disc injuries in the neck (1 in 139 000) or lower back (1 in 62 000).

In extremely rare circumstances, manipulations of the neck may damage a blood vessel and give risk to stroke or stroke-like symptoms (1 in 518 886 - 2.15 million). Other research shows that there is no link and that this is by chance.

**PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR CHIROPRACTOR.**
I have read the above and acknowledge I am aware of and understand the potential risks. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise her/his judgement during the course of the procedures which she/he feels, at the time, based upon the facts known, is in my best interests.

I have had the opportunity to discuss with the chiropractor and ask questions about the nature and purpose of the examination and treatment and all of my concerns. I understand that results are not guaranteed.

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% cancelation fee. If I fail to provide notice that I cannot 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.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ CHIRO'S SIGNATURE: _____

Questions to Ask: _____
_____