Admin: _____ ☐ SMS ☐ Cliniko ☐ Book ☐ Card ☐ Treatment notes ☐

TLC Birth & Beyond

PERSONAL DATA

Todays Date:__/__/____

Name _____Age ____DOB ___/___/____ Occupation _____

Address _____City _____PostCode_____Mobile Phone _____

E-mail address_____@_____ Marital Status ❑ S ❑ M ❑ D ❑ W

Spouse/Partner _____Emergency Contact(Name/Number):_____

Parent or Guardian name(if you are under 18) _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel TLC Birth & Beyond can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work Sleep Walking Exercise/sports Eating Love life Parenting

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Massage Therapist ❑ Physio/Osteo

Name of Health Practioners & Reason:_____

PHYSICAL STRESS: PREVIOUS PREGNANCIES

How many Pregnancies have you had?_____How were they delivered?_____

Have you had complication following any of these births?_____

YOUR BIRTH AND INFANCY

The birth process can traumatise a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps

❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

CHILDHOOD THROUGH ADULT

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N. If yes, list location and date of injuries: _____

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N. If yes, state reason and dates: _____

_____

Do you currently have any digestive issues? ❑ Y ❑ N If yes, explain: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are, currently, experiencing any of the emotional stresses below:

Family	Y	N						
Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Illness	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Other _____		

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list: _____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications/supplements (prescribed and over the counter): _____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

Do you exercise regularly? If yes, how often? _____

Do you follow a special dietary regime? _____

Do you suffer from headaches? ❑ Y ❑ N If yes, how often and type: _____

Initial Comprehensive Exam: $140. Regular Visit: $60. Extended Session (30min) $90.

Family Visit (3 or more people under the same roof booked at same time): $47 per person.

Please describe the Pain you're in

Where do you experience the most Pain? : _____

Was there an injury related to this pain, if so state when and what happened: _____

_____

When did the most current pain begin: _____

Is the pain (Circle): - - Constant - - Waking you up at night - - Occasional - - Only when you move a certain way.

Describe the pain (Circle): Sharp Shooting Dull Aching Throbbing Other: _____

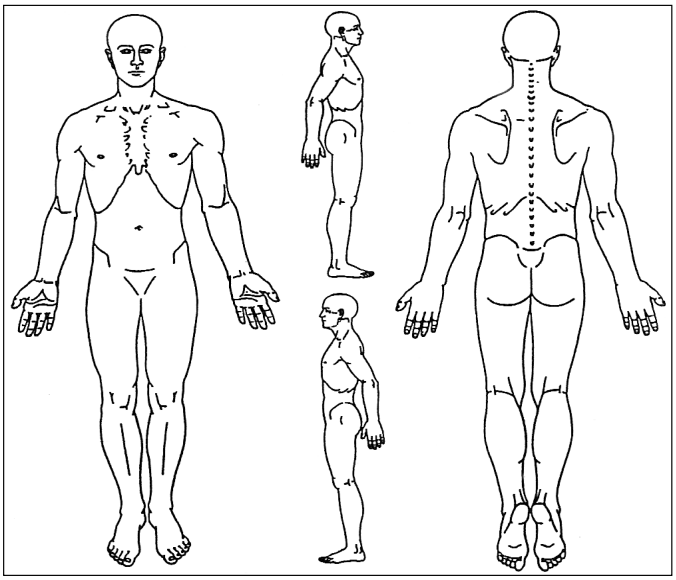
Does the Pain Spread out away from initial site of pain, if so where : _____

Severity of pain (0 = no pain, 10 = dropped into a pot of boiling oil): on average is ___/10 at its worst___/10.

What makes it better: _____

What makes it worse: _____

Is there anything else unique about your pain we should know : _____



Please Circle Location of pain on the body to the right.

Spinal Analysis – Completed by Dr.

C0 _____
C1 _____
C2 _____
C3 _____
C4 _____
C5 _____
C6 _____
C7 _____
T1 _____
T2 _____
T3 _____
T4 _____
T5 _____
T6 _____
T7 _____
T8 _____
T9 _____
T10_____
T11_____
T12_____
L1 _____
L2 _____
L3 _____
L4 _____
L5 _____
SI Jt_____
Sacrum_____

Ortho/Neuro

Kemps_____ MCC _____

Abnormal DTR: - @_____

Abnormal Muscle strength test:_____

Rhomberg: - / +

	Cervical	Pain	Lumbar	Pain
Flex	___(75)	No	___(90)	No
Ext	___(55)	No	___(30)	No
LFlex:L	___(45)	No	___(30)	No
LFlex:R	___(45)	No	___(30)	No
Rot:L	___(80)	No	___(30)	No
Rot:R	___(80)	No	___(30)	No

Comments:

Ribs:Ant:_____Post:_____

_____

_____

_____

_____

_____

Informed Consent to Chiropractic Care

Changes to the law now require all chiropractors to warn people of material risks, associated with all health care procedures, including Chiropractic.

As in all health care procedures, there are some slight risks with chiropractic care. This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [1];
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments) [2] [3].

Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs [4] and safer than driving a car [5].

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding. [6] [7] this is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates ***unexpected improvement*** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health. [8] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14% eyes/vision.

Broken down into subcategories the benefits were reported as follows:

- Easier to breathe: 21%
- Improved digestive function: 20%
- Clearer/better/sharper vision: 11%

(The references for the information quoted above are provided below.)

Agreement:

I have read and understand the information above. I understand that most care is given in an open setting. A private room is available upon request.

I consent to receive communication from TLC Birth and Beyond via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

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 his/her judgment during the course of procedures which he/she feels, at the time, based upon the facts known, is in my best interests.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I will have the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation. Should my currentdoctor cease care I give permission for him to pass on my file to the next Doctor.

I give the Chiropractors at TLC Birth and Beyond permission to render care to me today and at future visits. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature: _____ Print Name: _____

Chiropractor signature: _____ Date: _____/_____/_____

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8);530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9);42-47.
(6) Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15; 22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999; 22:559-64