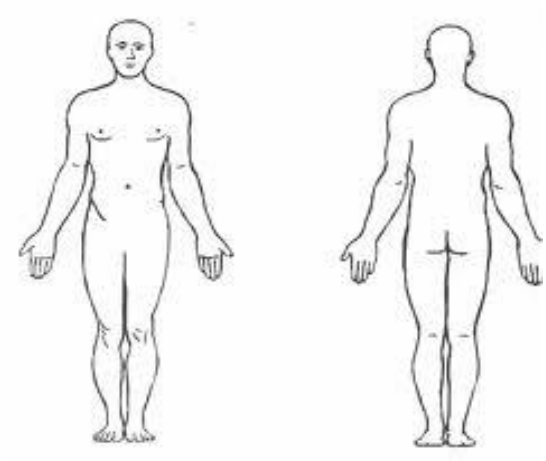
DETAILS	
Title: Mr Mrs Ms Dr Mast Miss	
Name:	
Address:	
Suburb/Town:	Postcode:
DOB:	Mobile:
Emergency Contact:	Email:

Current Major Complaint

Describe your current condition: _____

_____

Please indicate the area(s) of discomfort on the diagram (on right):



Please indicate the severity of discomfort you are experiencing right now:

1 2 3 4 5 6 7 8 9 10

No pain Discomfort Very sore Extreme pain

Does your condition interfere with: Work□ Sleep□ Routine□

What makes your symptoms better?_____

What makes your symptoms worse? _____

When did your symptoms start?_____

Are they getting worse? Yes □ No □

Has this occurred before? Yes □ No □

If so, when did it occur?_____ How often?_____

Do you know what caused it? _____

Have you received any treatment for this condition? If so, please list: _____

Was it effective? Yes □ No □

Chiropractic History

Have you ever had Chiropractic care before? Yes □ No □

If so, when was your last visit? _____

Name of Chiropractor: _____ Suburb/Town _____

Were X-rays taken? Yes □ No □

How would you rate your results? Excellent □ Good □ Poor □

PATIENT INFORMATION

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke symptoms (approx 1 / 5.85 million, Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this clinic we are still required to warn. If such procedures are required as part of your treatment you will be fully tested beforehand in advance, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc < 1 /139000 in the neck or < 1 / 62000 in the low back. (Dvorak study in Principles & Practice of Chiropractic, Haldeman. 2nd Ed)

Chiropractic care of spine-related conditions are internationally recognised as being far safer than dealing with pain management medications and many other alternative interventions. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. & Magna Report, Ontario Ministry of Health 1993)

CONSENT TO CARE

Chiropractic care is recognised as being an effective and safe form of treatment for many conditions. In this clinic we specialise in a unique & integrative CBP (Chiropractic Biophysics) as well as ABC (Advanced Biostructure Correction) systems of spinal correction using traction & specific exercises. However, please understand and be informed that there are risks associated with all health care procedures.

Please read the following carefully:

1) I acknowledge that the treating doctor has discussed with and explained to me the rare risks associated with my proposed care which includes although are not limited to muscle & joint soreness or strains, nausea and dizziness, fractures, disc injuries, stroke (or like episodes) and an exacerbation and/or aggravation of my underlying conditions.

Signature & date: _____

2) I understand I will be given (upon request – separate appointment to be made) the opportunity to discuss with the doctor and ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have right to withdraw consent any time prior and during treatment.
3) I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

4) I do not expect the practitioner to be able to anticipate all potential risks & complications associated with the proposed care.

5) **FOR FEMALES ONLY**
It is my responsibility to inform the treating practitioner at the earliest possible instance that expected / unexpected pregnancy is suspected or confirmed. The doctor reserves the right to terminate or modify treatment.
I ☐ **have** / ☐ **do not have** any augmented breast structures and/or associated prosthetics.

6) I hereby grant my consent to the performance of the proposed chiropractic examination & treatment by **Dr. Henry Lin**. I also understand that treatment may involve body parts that may not be directly related or close to my primary symptoms.

7) I understand that I can withdraw consent at anytime.

Patient's Signature **Print Name**

_____ _____

(Parent or Guardian to sign if under 18 years old)

Date _____

PRIVACY & CONFIDENTIALITY

At SpinoConcept we respect your privacy and by law we are required to keep your personal history and clinical records confidential.

However, in the process of offering the best solution and care possible for your condition/s other staff members (including other doctors and doctor's assistants) must also have access to some of your information. Such information is **strictly restricted for use by our staff within the clinic premise only**.

We have purposely set up the semi-open-plan treatment bays and rehab areas to facilitate our unique system of care. Please notify the front desk staff or doctor's assistant if you have special needs. Initial consultation and examinations that may require exposure of body parts are carried out in private rooms.

All 3rd Party Funded Cases Are Not Accepted

This clinic ONLY provides privately funded care to patients (wholly or partially through private health fund). With the exception being GP referrals under Medicare EPC (Enhanced Primary Care) scheme.

I understand that practitioner at this premise will not be involved with TAC, Work Cover, Veterans Affairs, Commonwealth Rehab or any other 3rd party organisations.

I agree to not disclose without prior consent, any details of this clinic to the above-mentioned organisation for the purpose of medical legal disputes and compensations.

Signature: _____ Date: _____

Cancellation Policy

If you have to cancel your appointment last minute, it is unlikely for other patient to take up the appointment in such short notice. Please do your best to provide us ***at least*** **24 hours notice** if you have to cancel your appointment.

Please also kindly note that a late cancellations/no-show will incur an admin/penalty charge of the equivalent missed appointment fee.

There may be circumstances (illness/accident/emergency etc) where special considerations apply. It will be determined on the basis of SpinoConcept admin team's discretion.

Re-scheduling Appointment

We understand that there may be times when you have work, school or family last minute commitments. Please re-schedule your appointment ***at least*** **24 hours** in advance to avoid an admin charge of the equivalent missed appointment fee. We strongly recommend that you book an alternate appointment in order to maintain consistency with your treatment plan.

I, _____(print name) have read and understood the above clinical administrative policy. I agree to these conditions for the service provided at SpinoConcept.

Signature: _____ Date: _____

Note:
We will send SMS (courtesy reminder) 2 days prior to your appointment. However, this is not to be relied on as there may be times where technical issue occurs. We strongly suggest that you should save future appointment time/s in your own calendar.