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 pregnancy!! **How many weeks are you?** _____
How many times have you been pregnant? _____ **How many child do you have?** _____
How old are your children? _____ **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? _____

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: ___ Worst: __ /10 Best: ___ /10
Condition 2						Average: ___ Worst: __ /10 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?** _____

Diet ___/10 ❒ 5 vegetables daily ❒ fruit daily ❒ 2L water daily ❒ coffee / tea ❒ "junk" food daily

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?** _____

Preconception Care

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

Pregnancy Health

Have you experienced any discomfort including nausea, heartburn, pain & other?
_____
Has there been any worries or complications? _____
_____
How many scans have you had done & when? _____
Where do you plan on giving birth? _____
Who is part of your birth & pregnancy support? ❒ GP Shared Care ❒ OB ❒ Midwife ❒ Doula

Previous Pregnancies

Have there been any difficulties with previous pregnancies? _____

Health History

Please list any medication (including supplements, contraception & recreational drugs):
Current: _____
Significant Previous: _____

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 <u>you</u> 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 <u>your Family</u> suffered any major or recurring conditions? Please indicate relationship to you for each condition in your family history. Examples as listed above.
_____
_____

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

There's been several research studies looking at the benefits of chiropractic care during pregnancy. Research has shown that women receiving chiropractic care deliver with **more comfort**, require **less pain medication** by 50% and had **shorter labours** by an average of 24% for first time mums and 39% shorter for women delivering for the 2nd or 3rd time [1, 2, 3].

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 after the first treatment. 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: _____
_____

1. Henderson, I. American Medical Association records released in 1987 during trial in U.S. District Court Northern Illinois Eastern Division, No. 76 C 3777, May 1987.
2. Freitag P. Expert testimony of P. Freitag, M.D., Ph.D., Comparing the results of two neighbouring hospitals, U.S. District Court Northern Illinois Eastern Division, No. 76 C 3777, May 1987.
3. Fallon, J. The Effects of Chiropractic Treatment on Pregnancy and Labour: A Comprehensive Study. Proceedings of the World Federation of Chiropractic, 1991: 24-31.