Total Body Fusion
Whole Body Treatment For Whole Body Relief

NEW PATIENT FORM

Date: _____/_____/_____

First Names: _____ Last Name: _____

DOB: _____/_____/_____

Home Address: _____

Phone: (H) _____ (W)_____ (M) _____

Email: _____Occupation: _____

Number of children and ages: _____

How did you hear about our clinic: _____

What physical activity do you do: _____

Appointment reminder to be sent: ☐ Email ☐ SMS

Do you wish to receive our newsletter: ☐ Yes ☐ No

NEXT OF KIN DETAILS:

First Names: _____ Last Name: _____

Relationship: _____Contact number: _____

PRESENTING COMPLAINT:

Please describe your present problem: _____

_____

When did this problem start? _____What were you doing_____

What makes it worse? _____

What makes it better? _____

Please tick the feelings associated with this problem:

Health Check				
	☐ Sharp Pain	☐ Dull Pain	☐ Ache	☐ Weakness
	☐ Throbbing	☐ Numbness	☐ Shooting	
	☐ Gripping	☐ Burning	☐ Tingling	

How frequent is the feeling?

☐ Constant (100%) ☐ Frequent (>50%)

☐ Occasional (25-49%) ☐ Intermittent (<25%)

How would you describe the intensity now (please mark the line):

_____

No Pain Unbearable

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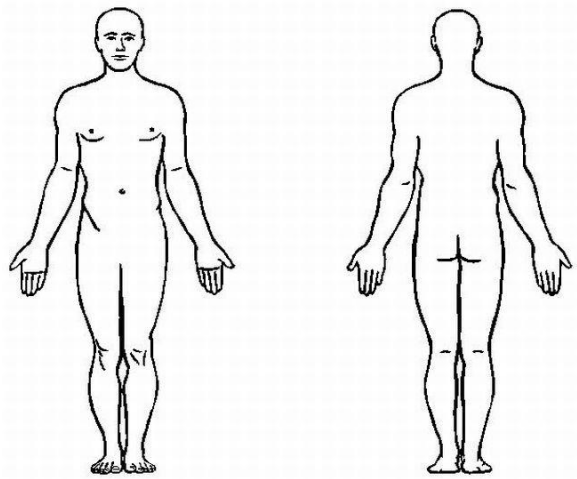
Please mark on the pictures where you have pain or other symptoms:



Are your symptoms: ☐ Increasing ☐ Decreasing ☐ Not changing

Are your symptoms worse: ☐ Morning ☐ Afternoon ☐ Increases through the day

☐ Same all day

Have you been treated for this problem before? Yes ☐ No ☐

If Yes, by whom?: _____

Have you had a similar problem before? Yes ☐ No ☐

If Yes, how was it cared for? _____

What two outcomes do you want from today's appointment:

1) _____

2) _____

FAMILY HISTORY:

Has any of your immediate family had any of the following conditions?

Cancer Yes ☐ No ☐

Blood Pressure Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Stroke Yes ☐ No ☐

Heart trouble Yes ☐ No ☐

Migraine Yes ☐ No ☐

Other _____

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MEDICAL REVIEW:

Do you have now, or have you ever had, any of the following (Please tick):

Unexplained weight loss	Yes ☐ No ☐	Any heart trouble	Yes ☐ No ☐
Excessive fatigue	Yes ☐ No ☐	Pain or pressure in chest/Angina	Yes ☐ No ☐
Prolonged fever/chills	Yes ☐ No ☐	Palpitation or pounding heart	Yes ☐ No ☐
Cold or heat intolerance	Yes ☐ No ☐	Rheumatic fever	Yes ☐ No ☐
Excessive thirst or hunger	Yes ☐ No ☐	Swelling of ankles	Yes ☐ No ☐
Frequent or severe headaches	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐
Wear glasses or contact lenses	Yes ☐ No ☐	High cholesterol	Yes ☐ No ☐
Chronic nasal discharge/sneezing	Yes ☐ No ☐	Atherosclerosis	Yes ☐ No ☐
Impaired hearing	Yes ☐ No ☐	Pain in joints/arthritis	Yes ☐ No ☐
Memory loss	Yes ☐ No ☐	Chronic back pain or injury	Yes ☐ No ☐
Fainting, dizziness, convulsions	Yes ☐ No ☐	Anaemia	Yes ☐ No ☐
Change or new growth in mole	Yes ☐ No ☐	Excessive bleeding/bruising	Yes ☐ No ☐
Breast lump	Yes ☐ No ☐	A blood transfusion	Yes ☐ No ☐
Chronic cough	Yes ☐ No ☐	Any swelling of lymph glands	Yes ☐ No ☐
Asthma or wheezing	Yes ☐ No ☐	Mid-cycle bleeding (females)	Yes ☐ No ☐
Shortness of breath	Yes ☐ No ☐	Are your periods regular (females)	Yes ☐ No ☐
Shortness of breath at night	Yes ☐ No ☐	Painful periods (females)	Yes ☐ No ☐
Abdominal Pain	Yes ☐ No ☐	Pain with intercourse (females)	Yes ☐ No ☐
Loss of appetite	Yes ☐ No ☐	Have you ever been pregnant	Yes ☐ No ☐
Change of bowel habits	Yes ☐ No ☐	Problems with sexual function	Yes ☐ No ☐
Blood in stools	Yes ☐ No ☐	Osteoarthritis	Yes ☐ No ☐
Hemorrhoids or rectal disease	Yes ☐ No ☐	Rheumatoid arthritis	Yes ☐ No ☐
Frequent urination at night	Yes ☐ No ☐	Diabetes Mellitus	Yes ☐ No ☐
Frequent or painful urination	Yes ☐ No ☐	Trouble sleeping	Yes ☐ No ☐
Difficulty holding urine	Yes ☐ No ☐	Often depressed	Yes ☐ No ☐
Difficulty stop/start urine flow	Yes ☐ No ☐	Often anxious or nervous	Yes ☐ No ☐
Urinary tract infection	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐

Previous surgery/hospitalisations? Yes ☐ No ☐
Description _____

Previous fractures/dislocations? Yes ☐ No ☐
Description _____

Major accidents (incl. motor vehicle)? Yes ☐ No ☐
Description _____

Medications/Vitamins/Supplements? Yes ☐ No ☐ List _____

_____

What is your stress level like (1 minimal, 10 major/burnout)? _____ Major cause? _____

Do you smoke? _____/Qty per day Do you drink alcohol?_____/Qty per week

Name and address of GP _____

Do you consent to the clinic writing to your GP and informing him/her that you are being treated at this clinic?
Yes ☐ No ☐

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION INCLUDING SENSITIVE AND HEALTH INFORMATION

Information is collected from you in a lawful manner fairly and without undue intrusion. Total Body Fusion uses information only for the purposes for which it was collected.

Patient's Name _____Date _____/_____/_____

Patient's Signature _____ (or Guardian if patient is a minor)

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CONSENT TO CHIROPRACTIC CARE – *(fill in this section after speaking with Dr Steel).*

Chiropractic care is recognised as being an effective and safe method of care for many conditions.
However, you must recognize that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully;

1. I acknowledge that I have discussed with Dr Sandra Steel the core risks associated with my proposed care which include but are not limited to muscle and joint soreness or strain; nausea and dizziness; fractures; disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms; strokes (or like episodes); and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me:

3. I have had the opportunity to discuss the proposed care with Dr Sandra Steel. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by Dr Sandra Steel. I understand that I can withdraw consent at any time.

7. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics between 1 in 2 million to 1 in 5.85 million (Haldeman, et al. Spine Vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics less than 1 in 139,000) and the low back Haldeman 2nd Ed). For some patients, especially with bone weakening diseases, a fracture of a bone, although rare, is possible.

_____ _____

Print Patient's Name

Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

_____ _____/_____/_____

Dr Signature

Date