# The Bianchi Clinic

## Initial Consultation

**PLEASE TICK WHERE APPLICABLE AND COMPLETE WITH FULL DETAILS**

Full Name: ____________________________________________ Consultation Date: ____/____/____

Address: ______________________________________________ Date of Birth: ____/____/____

Suburb ________________________________________ State: _______ Post Code: _________

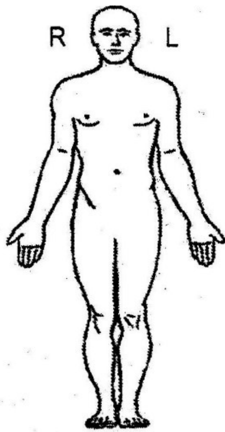
Phone Home: _________________ Mobile: _________________ Work: _________________

Email: ____________________________ Gender: ❑Male ❑Female ❑Gender Neutral ❑Other

Please describe in your own words the reason for today's visit, both any major issues and any other concerns or problems: ________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________




Please mark on the diagram: "X' for pain, "0" for numbness & "Z" for discomfort.

1. Did this problem occur after a specific event? ❑Yes ❑No, If Yes please specify:

__________________________________________________________________________

If Yes, how long ago did it happen? _____________________________________________

2. How long have you had the problem? __________________________________________

3. Have you had a similar condition in the past? ❑No ❑Yes

4. Does it affect your ❑Arms ❑Legs ❑Other (please use the diagram)

5. Is it: ❑Sharp ❑Dull ❑Both ❑Numbness ❑Pins & Needles ❑0ther

6. Is it ❑Constant ❑Recurring / Intermittent

7. Is it ❑Getting worse ❑Improving ❑Same/ Unchanging

8. What makes it feel better? ❑Rest ❑Heat ❑Ice ❑Rubbing ❑Movement ❑Not sure

❑Other: ______________________________________________________________

9. What makes it feel worse? ❑Sitting Standing ❑Moving ❑Coughing

❑Morning ❑Night ❑Not sure ❑Other: ___________________________________________

10. Does it interfere with: ❑Work ❑Sleep ❑Walking ❑Sitting ❑Hobbies ❑Leisure ❑Sporting Activities

11. Have you consulted other Doctors for this problem? ❑No ❑Yes

If yes ❑Chiropractor ❑Medical Dr ❑Other: ________________________________________

12. Did the treatment help? ❑No ❑Yes ❑Somewhat

13. Are you taking any Medication/Vitamins/Supplements? ❑No If yes, please tick: ❑Pain Killers ❑Anti-inflammatory ❑Other, please specify: _____________________________________________________________

________________________________________________________________________________________

**Please Turn Over**

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## PATIENT HISTORY

14. Have you been to hospital for anything at all? ❑No ❑Yes, If Yes please specify:

_______________________________________________

_______________________________________________

15. Have you had any x-rays or tests? ❑No ❑Yes, If Yes please specify: _______________

_______________________________________________

16. What has the pain stopped you from doing that really concerns you?

_______________________________________________

_______________________________________________

_______________________________________________

17. How committed are you to resolving this problem or condition? Slightly ❑Moderately ❑Very Committed

18. **Physical Trauma's and Medical History**, please detail any past or present medical traumas, events or conditions i.e. Broken or fractured bones, cervical & spinal injuries or conditions, Joint injuries and or dislocations, whiplash, car crashes, stroke, surgeries, major illnesses etc...

**Please Note: Full disclosure is required to ensure you can be correctly diagnosed and safely treated.**

_______________________________________________

_______________________________________________

_______________________________________________

19. **Emotional / Psychiatric trauma or conditions** (Note that disclosure is both optional and confidential)
Do you have any traumas present or historical and or conditions you would like to disclose or feel may influence or come up during treatment? ❑No ❑Yes

Please tick a box and or a specify: ❑Physical abuse ❑Emotional Abuse ❑Sexual Abuse ❑Depression or Anxiety

❑ Other - please specify: _______________________________________________

20. With the following emotional stress situations, please put a **P** for a **Past** or **C** for a **Current** stress & rate the stress as mild, moderate, &/or extreme. (See example of a past moderate childhood stress)

| | Mild | Moderate | Extreme |
|---|---|---|---|
| **Childhood stress** | | **P** | |

| | Mild | Moderate | Extreme | | | Mild | Moderate | Extreme |
|---|---|---|---|---|---|---|---|---|
| Childhood stress | | | | | Work related stress | | | |
| School stress | | | | | Stress of commuting | | | |
| Play or Recreational | | | | | Loss of loved one | | | |
| Family stress | | | | | Change in lifestyle | | | |
| Personal relationships | | | | | Change in vocation | | | |
| Stress of being sick | | | | | Abuse | | | |

21. Do you have any other complaints?

_______________________________________________

_______________________________________________

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# PATIENT HISTORY

22. Please TICK the box/s if the description relates to a symptom or medical condition you have:

☐ Dizziness from head movements
☐ Migraines / Headaches Cl
☐ Osteoporosis/Fractures
☐ Eczema
☐ Glaucoma
☐ Eyes flicker involuntarily with head movement
☐ Difficulty in swallowing
☐ Rheumatoid Arthritis
☐ Allergy
☐ Epilepsy
☐ Numbness down one side of face/ tongue/ body
☐ Slurred speech
☐ Spinal Trauma or Surgery
☐ Asthma
☐ Convulsions
☐ Seeing double or other visual disturbances
☐ High Cholesterol
☐ Multiple Sclerosis
☐ Anemia
☐ Paralysis
☐ Drop attacks or loss of consciousness
☐ High blood pressure
☐ Dislocations
☐ Pleurisy
☐ Impotence
☐ Falling to one side when walking
☐ Nausea or Vomiting
☐ Diabetes
☐ Cancer
☐ Polio or TB
☐ Stroke or Aneurysm
☐ Ligament or Disc Rupture
☐ Rheumatic Fever
☐ Spot Bleeding
☐ Hepatitis
☐ Vertigo or Unsteadiness
☐ Bone or Joint Infection
☐ Loss of bladder or bowel control
☐ Swelling/Lumps
☐ HIV

If your condition or symptoms are not listed please specify:

________________________________________________________________________________

________________________________________________________________________________

**Clinic Policy's:**

1. Cancellations & Booking Changes: We require a minimum of 4 hours notice of cancellations or changes; more notice is appreciated if possible. A $50 cancellation fee is chargeable at our discretion for cancellation or changes under 4 hours notice.
2. Late Arrivals: While we will do our best to accommodate where possible, late arrivals over 15 minutes may require that we re-schedule as we will not inconvenience later clients to accommodate arrivals over 15 minutes late.
3. Payments: All treatments, services and purchases are to be paid for on or before the day of service, please note that the Clinic does not offer patient accounts.

**Important Patient Information**

The law requires that all practitioners who make corrections or adjustments to the spine warn patients of any material risk. (even if extremely low)
In extremely rare circumstances, some treatments of the neck may damage blood vessels and give risks to stroke or stroke like symptoms (approx. 1 in 5.85 million neck manipulations). [Haldeman, et al. Spine Vol 24-8 1999].
Whilst this has never occurred in this or any practice the Chiropractor has worked in, we are still required to warn you of this risk.
If any adjustments (manipulations) are required, you will be tested for the appropriate risk indicators beforehand.
Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). [Dvorak study in principles and practice of Chiropractic, Haldeman. 2nd Ed.].
Chiropractic adjustments (manipulations) of the spine are internationally recognized being far safer in dealing with neck and low back pain than medication and many other alternative treatments. [A Risk Assessment of Cervical Manipulation, JMPT, 1995. Mango Report, Ontario Ministry of Health, 1993].
***If you have any questions related to the treatment you are about to receive, please speak to the Chiropractor.***

**Patient Declaration:** I have read and discussed the above information with the Chiropractor and give my consent to treatment. I give my full permission for Dr Jarad Bianchi to share my information within the practice and to other allied health professionals (such as my doctor) if it may improve my health outcome. I can withdraw this permission at any time. I have disclosed all information regarding my current and historical health conditions, traumas & treatment history that may influence the practitioner's diagnosis and treatment decisions.

Patient's Signature: ___________________________

Print Name: __________________________________ Date: ____/____/_____