longueville road chiropractic centre
health care for the long road of life

221 Longueville Road, Lane Cove NSW 2066 Tel: 9418 3930

Welcome to Longueville Road Chiropractic Centre. Please complete all the questions on this form as accurately as possible as this information will help us determine if Chiropractic can help you. Feel free to ask for assistance with any questions.
Catherine von Thomann & Associates

HISTORY

Surname: Given Names:

Address:

Post Code:

Email: I would like to receive LRCC e-newsletter Yes/No

Telephone: Home: Business: Mobile:

Date of Birth: DD / MM / YEAR Age:

Health fund. Yes/No. If so, which one?

Type of work: Employer:

Name of Emergency Contact: Phone No.

Are you: Married☐ Single☐ Widowed☐ Separated☐ Number of Children:

Have you had previous Chiropractic care Yes/No. For what problem?

I would like help with the following condition:

How long have you had this complaint?

What makes this condition worse?

What (if anything) relieves symptoms?

Is your condition: Getting Worse☐ Same☐ Getting Better☐ Constant Pain☐ Comes & Goes☐

Do you have any health concerns? Yes/No. Give details: eg Stress, aches & pains, etc

How did you find out about our services? Flyer☐ Yellow Pages☐ Internet☐ Friend☐ name

Drive Past☐ Referral from Health Professional☐ name Other☐

Trauma	**Yes**	**No**	**If YES, when?**
Have you ever:			
Been knocked unconscious	☐	☐	____________
Use a cane, crutch or other support	☐	☐	____________
Been treated for spine or nerve disorder	☐	☐	____________
Had a fractured bone	☐	☐	____________
Been involved in a motor vehicle accident	☐	☐	____________
Been involved in a motor cycle accident	☐	☐	____________
Been involved in a heavy fall	☐	☐	____________
Been Hospitalized / surgeries	☐	☐	____________

____

____

Any X-rays, CT scan, bone or organ scans	☐	☐	____________

____

- Do you sleep on your stomach? Never ☐ Sometimes ☐ Always ☐
- Is your bed: Soft☐ Firm☐ Hard☐ Other______________________
- Do you wear any supports for any of the following? Foot, Back, Limb, Other__________
- Do you smoke? Yes / No. If yes, number per day_____
- Number of cups of coffee or tea per day_____

Activities/sports/exercise programs/hobbies – past or present:

____

____

Current medications/supplements:

____

____

____

Do you have a family history of ANY illnesses etc? (eg asthma, diabetes, migraine, heart disease, high blood pressure, cancer…)

Name	Relation	Past & Present Health Problems

Medical History:

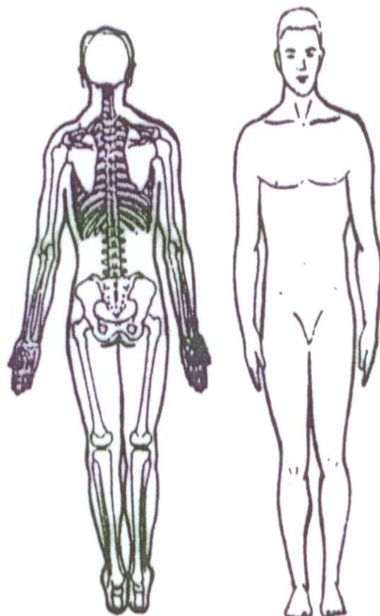
TICK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

☐Alcoholism	☐Celiac Disease	☐Goitre	☐Pleurisy	☐Scarlet Fever
☐Alzheimer’s	☐Chicken Pox	☐Heart Disease	☐Pneumonia	☐Shingles
☐Anaemia	☐Diabetes	☐Malaria	☐Polio	☐Stroke
☐Appendicitis	☐Diphtheria	☐Measles	☐Polycystic Ovary	☐Tuberculosis
☐Arthritis	☐Eczema	☐Mental Disorder	☐Psoriasis	☐Ulcer
☐Asthma	☐Emphysema	☐Multiple Sclerosis	☐Rheumatic Fever	☐Venereal Inf.
☐Cancer	☐Epilepsy	☐Mumps		

TICK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 12 MONTHS

☐Low Back Pain	☐Numbness/Paralysis	☐Digestive Problems
☐Shoulder Pain	☐Dizziness/Fainting	☐Abdominal Discomfort
☐Neck Pain	☐Convulsions	☐Bowel Problems
☐Arm Pain	☐Cold/Tingling Extremities	☐Bladder/Kidney Problems
☐Joint pain/stiffness		
☐Walking problems	☐ Allergies	☐Menstrual Problems
☐Difficulty chewing/clicking jaw	☐ Headaches/Migraines	☐Vaginal Pain/Infections
☐Leg Pain	☐ Sleep Problems	☐Breast Pain/Lumps
	☐ Poor/Excessive Appetite	☐Prostate problems
☐ Vision Problems		☐Sexual Dysfunction
☐ Dental Problems	☐Chest Pain	☐Genital Infection
☐ Hearing Problems	☐ Shortness of Breath	**FEMALES ONLY:**
☐ Ringing in Ears	☐ High/Low Blood Pressure	Date of Last Period________
☐ Sinus Problems		Are you pregnant?
		☐Yes ☐No ☐Maybe

Please mark on the diagram the areas of your discomfort.



Details:________________________________

____

____

____

____

____

____

____

____

____

LONGUEVILLE ROAD CHIROPRACTIC CENTRE

221 Longueville Road Lane Cove, NSW 2066 Tel: 9418 3930

Schedule of Fees

Effective 1st January, 2014

Initial Consultation, Examination & Adjustment……………..$110.00

Initial Consultation, Examination & Adjustment…(Child)……$70.00

Report of Findings & Adjustment..…$95.00

Extended Consultation & Adjustment ....…$80.00

Standard Consultation & Adjustment ....…$58.00

Pensioner, Student...…$50.00

Children (Under 12 years)………………………………...$50.00

Low Level Laser Therapy (LLLT) …………………………….$72.00

Neuro Emotional Technique (NET)..$80.00

Acupuncture (Dry Needling)…………………………………...$80.00

Please Note:
We do not keep accounts.
Please observe our 'missed appointment' policy.

A percentage of consultations may be claimable through your private health fund.

I have read the above and undertake to pay at the time of consultation.

Signed…………………………………………………………

Date……………………………………………………………

CONSENT TO TREATMENT

Chiropractic treatments, including spinal adjustments are an effective treatment for spinal pain, headaches and other nervous system related problems. Chiropractic is internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives[1].

Changes to the law now require all practitioners who manipulate the spine to warn patients of any potential risks. In extremely rare circumstances, some treatments of the neck may give rise to stroke or stroke-like symptoms. This risk is approximately 1 in 5.85 million neck manipulations[2]. Whilst this has never occurred in this practice, we are still required to warn our patients.

If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice. It is note worthy that the common medical approach to neck pain, that of prescribing non-steroidal anti-inflammatory drugs (e.g. aspirin) has 400 times greater chance of causing serious complication than a chiropractic adjustment[3].

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).

If you have any questions related to the treatment you are about to receive, please speak to the chiropractor.

- I acknowledge that I have read and understood the above information and have had the opportunity to discuss this information with the chiropractor.
- I hereby give my consent to treatment by signing below.

____

Patient's Signature

____

Patient's name printed

___________________________________ ____________

Chiropractor's Signature Date

[1] A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.
[2] Haldeman S, Kolbeck FJ, McGregor M (1999). Risk factors and precipitating neck movements causing ver
[3] Dabbs V, Lauretti WJ. Risk assessment of cervical manipulation vs. NSAIDs for the treayment of neck pain. JMPT 1995; 18; 530-536.