Thank you for choosing Burswood Health Professionals for your spinal health and chiropractic. Please take a little time to read the following information about your first visit at Burswood Health.

Paperwork. Please complete the "New Client Form" you have downloaded**.**

How long? Please allow between 60–90 minutes for your first consultation. This consultation will comprise of:

- A short DVD which outlines our clinic approach towards chiropractic care
- A discussion with the chiropractor about your problem & history of your health
- A physical examination including spinal and joint function assessment
- A thorough explanation of your condition will be given on the first and/or second visit.
- Treatment relevant to your problem. Treatment is often, but not always, given on the first visit.

X-rays. X-rays are not necessary in all cases but may be taken to assist the chiropractor in determining the best treatment. If we consider that x-rays are needed, these will be conveniently performed on the premises. If you already have x-rays please bring relevant ones with you to this consultation. Other tests may be ordered.

Bring your partner: Your partner or parent is welcome to attend with you at any of your visits. We especially recommend you to bring someone along to your second visit – the *Report of Findings.* Having someone with you at this visit helps remembering our explanation and advice about the problem. When you are at home you can better discuss what was said during this important consultation.

What we do: We will recommend what in our professional opinion is the best solution to your problem. This can vary from a course of manipulation, to an ongoing program of care or include exercises and nutritional support and massage. Our care is targeted at results, as well as looking at problems holistically.
An Initial Care Program will be recommended if we feel we can help resolve your problem. A spinal care class may be scheduled which will help explain the work we do. Your partner is welcome to attend. The fee for this class is included in your first visit fee.

Payment: Fees for services are payable on the day of consultation. We accept all major credit and debit cards through EFTPOS facilities. We also accept cash and cheques. Remember health rebates may apply to some or all of the services billed. Please check with your health fund for amounts. Hicaps facilities are also available.

Cancellations: Your trust in us is important, as is our time and ability to serve others. We will attempt to contact you within 24 hours prior to this appointment to confirm your ability to attend. We charge for missed appointments and late cancellations (less than 12 hours). If, for any reason you cannot attend this appointment, please ring us as soon as possible to rearrange the time.

Service Guarantee: We are proud of our service and back this with a satisfaction guarantee. If you feel less than satisfied with our service within the first 7 days of commencing treatment we will refund fully all visit costs (excluding x-rays or products). We don't guarantee results, no one can – but we do guarantee our commitment to customer service.

Our website: Please visit our website at http://www.burswoodhealth.com.au for more information about the services we provide and testimonials from other clients.

Muscle chiropractors: We call ourselves 'muscle chiropractors' because we focus on both muscles and joint alignment as possible causes of problems and we treat accordingly. Many people seek our care because this approach is sensible, logical and less forceful than when adjustments / manipulation alone are used. We provide exercises and advice for you to assist your own recovery. This way results are achieved better and faster.

We look forward to meeting you.

Yours sincerely,

Reception, Burswood Health

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APPLICATION TO BECOME A CLIENT

Thank you for choosing Burswood Health Professionals to help you. We aim to provide top class evidence-based complementary and allied health care services focusing on both the acute care and wellness dimensions of health. We appreciate your patience in completing this questionnaire that asks about your problem and some aspects of your lifestyle. The information is necessary in assisting us to help you. If you need help please ask, and remember this information is confidential.

Last name ______ First ______ Middle ______

Street Address ______ Home Phone ______

Suburb ______ Postcode ______ Mobile ______

Occupation ______ Work Phone ______

Height ______ *cm* Weight ______ *kg* Date of Birth ______

Email Address ______ Health Cover ______

Medical Practitioner ______ Marital Status ______

Recommended by ______ Children ______

Previous chiropractor/s? ______ Last seen ______

Use the scale to show how you feel about your overall health:	**Bad**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Excellent**

Reason(s) for this consultation (your responses will assist in determining any additional information we will need from you before you see the chiropractor, podiatrist or therapist) (tick those appropriate)

1. ☐ Recent onset pain problem (within last month): Neck – Lower back – other
2. ☐ Chronic (long term) problem: Neck – Lower back - Other
3. ☐ Workers compensation claim
4. ☐ Motor vehicle injury claim
5. ☐ Personal injury claim using solicitor or other litigation
6. ☐ Pre-employment assessment
7. ☐ Spinal Check
8. ☐ Podiatry
9. ☐ Foot check
10. ☐ Soft tissue (massage) therapy
11. ☐ Nutritional, weight and fitness assessment

Do you have x-rays, CT Scans or MR imaging related to this problem already? If so please hand them to reception for the chiropractor to review (this may incur charges)

What is the MAIN thing you wish to be able to DO if we were able to provide you with a solution to your problem? (Your main expectation?)

______

______

______

______ %

My responses to this form and others completed today are accurate to the best of my knowledge.
If the client is a minor (under 18) permission is given for examination to proceed. *(tick)* ☐
I understand that there is a fee for missed appointments. Payment is due when the service is performed. ☐
Payment for services can be made by cash, cheque, credit card or EFTPOS.

Client / Parent / Guardian **Signature:** ______ Date ______

Your Privacy is important to us. This information will be used in the interests of your continuing health care and will be safeguarded under our Practice Policy on Privacy, to which you can have access on request.

NAME: ______________________ File number [ ]

SYMPTOM CHECKLIST

Date ____________

For each line and using a pen, tick (√) to indicate which is present now, or in the past. If never, tick (√) that box.

Question	Yes or Now	In Past	No or Never
On computer click a box for each line	■		
X-rays of spine are more than 5yrs old			
Pain worse at night			
Unexplained weight loss			
Use blood thinning medication			
Taken corticosteroids			
Injury or Trauma			
Older than 50 years			
Considering legal advice			
Accident caused this problem			
Unhappy with life generally			
Relationship problems			
Money or job problems			
Mattress is older than 10 years			
Stiff neck in morning			
Pillow is older than 3 years			
Need to adjust pillow often			
Muscle cramps			
Twitching eyelid			
Tight muscles			
Poor sleep quality, tiredness			
Nervous, anxious or depressed			
Stiffness in the lower back in the morning			
Various joints are stiff			
Aching if the weather is cold or changes			
Pain worsens throughout the day			
Often ache between the shoulders			
Long hours at a computer			
Long hours of cycling			
Teenager slumped posture			
Morning stiffness in joints			
Cracking, noisy knees			
Headaches?			

Question	Yes or Now	In Past	No or Never
Sore knuckles			
Old sports injuries			
Used antibiotics recently			
Bruise easily			
Exercise more than 3x/week			
Use foot orthotics			
Do you smoke?			
Difficulty sleeping			
Feel stressed?			
Use oral contraceptive?			
Motor Vehicle Accident Claim			
Workers compensation claim			
Seen a chiropractor before?			
Seen an orthopaedic surgeon?			
Other health professional seen?			
Taking non-prescription drugs?			
Regarding other body systems			
Circulatory problems			
Heart problems			
Chest problems			
Lung problems			
Digestive problems			
Bowel problems			
Urinary problems			
Ear problems			
Eye problems			
Skin problems			
Regarding immediate family			
Any arthritis?			
Any cancer?			
Any diabetes?			
Any stroke ?			
Any heart problems?			

Other: please elaborate in detail

Thank you. Your chiropractor will review your responses and may ask more questions to help determine if we can help you

Email your saved file to us (reception@burswoodhealth.com.au), or print the completed form and hand it to staff at reception.

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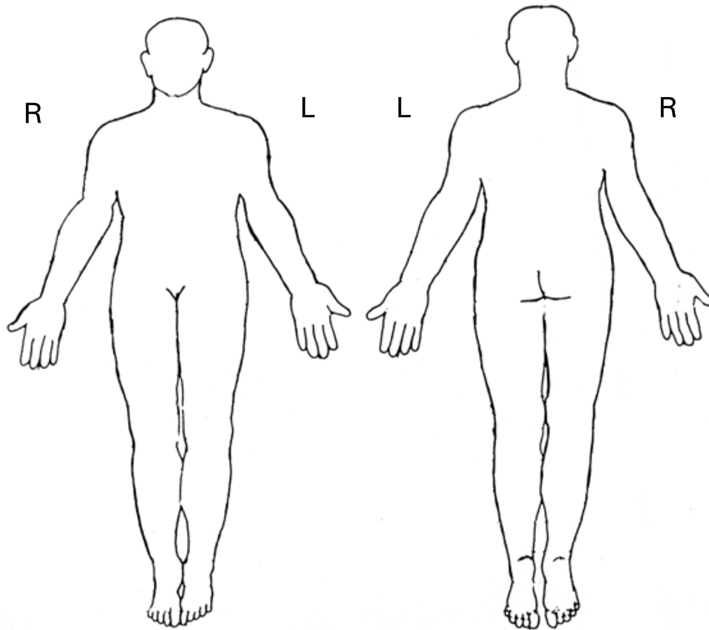
TELL US ABOUT YOUR PAIN PROBLEM

Thank you for being patient with the paperwork. We need to know about your pain. If you are here because of another problem, don't fill this form out. If you need help please ask, and remember this information is confidential.

Please indicate where your present symptoms are on the diagram below using the symbols on the right box.



Use these symbols to outline your problem area(s)

Aching Pain	= = = = = = = = = =
Burning Pain	xxxxxx xxxxxx
Numbness or pin & needles	000000 000000
Stabbing	////////// //////////

Other - *use your imagination*

Indicate the intensity of your *present* pain(s) on this scale (tick or circle)	**NONE**	1	2	3	4	5	6	7	8	9	10	**WORST EVER**

How long have these problems been present? ________ Days / Weeks / Months/ Years (circle one)

What do you think CAUSED this problem?

Have you had treatment for these problems? Y / N If so, from whom?

Results of this treatment?

Are you taking any medication for this or any other problem? Y / N If so, please list?

Any x-rays, CT Scans or MRI taken previously? Y / N If so, please list (include when)?

If you have prior x-rays or scans, please bring them to your next visit

Have you experienced similar episodes of pain in the past? Y / N If so, please explain?

Full Client Name:

Client / Parent / Guardian **Signature:** Date

Your Privacy is important to us. This information will be used in the interests of your continuing health care and will be safeguarded under our Practice Policy on Privacy, to which you can have access on request.