

Is the complaint getting worse or staying the same intensity over the last period of time.....

Things that aggravate the pain.....

Things that relieve the pain.....

History of the complaint before.....

Treatment for this complaint in the past.....

If present describe the pain.....

Sharp/dull/aching/deep/superficial/burning/shooting/other

Does the pain radiate anywhere. Have you ever had numbness, tingling or shooting pain down the arms or legs on a regular basis?.....

If yes is your limb pain sharp or dull in nature.....

Have you ever been diagnosed with a disc bulge before?.....

Describe the pain out of 10: 1 2 3 4 5 6 7 8 9 10 Please circle

When or how did the pain start?.....

Is the present constant or intermittent?.....

Does the pain keep you awake at night?.....

At what time of the day in the pain worst?.....

Is the pain relieved by finding a comfortable position or resting?.....

Is there a time when you have no pain at all like when you are in bed or sitting and not moving?

Does the pain start suddenly or gradually?.....

What sort of practitioner's have you seen before even for other issues?

Drugs for the complaint eg. Anti inflammatories or painkillers.....

Other fitness and lifestyle questions

How much exercise do you do a daily/weekly basis.....

How many colds do you get per year.....

Smoking Y/N

If so, state the maximum number of cigarettes per day

How many years have you been smoking? If you have given up, how long ago did you stop?

How many cigarettes did you smoke per day before you stopped?
Please state alcohol consumption per day / week: Day Week
Please state recreational drug use per day / week: Day Week
What is your level of stress? Mild/moderate/severe
Do you suffer from anxiety or depression?.....

.....
.....
What are your energy levels like? Bad/OK/Good/High
How long have you suffered from fatigue? weeks /months / years
What is the 24 hour pattern of your fatigue. Is it bad all of the time,
only bad in the afternoon, there on waking in the morning and
improves etc.....

.....
.....
Is your weight an issue for you?
Do you suffer from any diagnosed medical condition/s?
If yes please specify:.....

.....
.....
Have you ever had surgery? If so what procedures and what year
were they done?.....

.....
.....
Have you had X Rays before? If so why and what parts? In relation to
the region in your body that has pain can you bring the X Ray report
into the treatment with you.

Very Important please note:
If you do not have a copy of the report look on the X ray envelope and
**ring up the radiology house and get them to fax me a copy of the
report to 9525 2982 in advance of our treatment.** It is important
I have all available information at the outset before I treat you.
Have you seen any health practitioners in the last 12 months?
If yes specify the complaint/s, the treatment/s given and any
investigations undertaken:

.....
Accidents

Have you been involved in any accidents in the past eg. Horseriding,
skiing, motorcar / bike, contact sport or other?.....Page4

.....
.....
Have you broken any bones in the past and if so which ones?
.....

Have you ever been hit in the face or the head even as a kid Yes / No
What part of the face or head was impacted?

.....
Have you had concussion or been unconscious before? Yes/No
.....

.....
Have you ever had a bad fall on your backside before?.....

.....
Did you have an easy or complicated birth? Were forceps used or any other obstetric interventions used to facilitate your entry into this world? If you don't know ask your parents if they are still alive. As a Cranial Osteopath it is important information to know.

.....
.....
Previous History

Please list in order any major/unusual illnesses that you have had in the past starting from childhood eg. Bronchitis, glandular fever, cancer, giardia, tummy bugs when travelling, pneumonia, asthma, eczema, high blood pressure, hepatitis, HIV, gall bladder problems
.....
.....

.....
Current Medication:

Please indicate any medications you are currently taking. This includes prescription and non prescription drugs and supplements...
.....

.....
Have you had any teeth extractions or substantial dental work before? eg. Removal of wisdom teeth
.....

.....
Family History

Have any of your nearest relatives had a major illness such as epilepsy, heart disease, cancer, diabetes, allergic asthma, hayfever, sinusitis/other.....
.....
.....

Headaches Yes/No **Migraines** Yes/No How often?

Do you suffer from headaches at work. Yes / No. After work. Yes / No

At weekends Yes / No. When.....

State frequency of headaches: Per Week Per Month

Does the headache occur at the time of eating or soon after? Yes /No

What is their pattern?.....

Does the headache seem related to working / living in certain places?

Yes /No

Is the headache related to the menstrual cycle? Yes/No

Do you feel over sensitive to noise or bright lights? Yes/No

Do you get blurred vision? Yes/No When?.....

Eye problems.....

Ear problems.....

Throat problems.....

Sinus problems.....

Mouth problems.....

Skin, hair or nail problems.....

Heart problems.....

Lung problems.....

Digestive Tract problems

Do you ever suffer from indigestion and/or flatulence after meals?

Yes/No

Do you pass a lot of gas, become bloated with gas, or suffer any cramping abdominal pain? Yes /No

Do you suffer from hemorrhoids (piles)? Yes /No

Do they ever bleed? Yes /No or become itchy? Yes/No.....

How often do you open your bowels on average? (e.g. once every 1 to 2 days).....

.....
If your bowels open regularly at present, have you had any history of constipation over several months? Yes /No

.....
Do you have a tendency towards diarrhea or occasional explosive bowel motions? Yes /No.....

Do you use laxatives? Yes /No

If so, what type and how often?

Have you had ANY CHANGE OF BOWEL HABIT recently? Yes /No.....

.....
Do you ever get nauseated? Yes /No. Vomit? Yes /No

How often?.....

Have you LOST ANY WEIGHT recently? Yes /No

Have you had a history of antibiotic use?

Kidney or bladder problems.....

Circulation problems.....

Do you get leg cramps? Yes /No How often?

Sexual issues/genital infections.....

Sleep problems. If yes is it a problem getting to sleep or staying asleep or both and how long has this been the case for?
.....
.....

Other

Do you suffer from dizziness? Yes/No/Sometimes

If yes, please explain when you get it. eg. Only on sitting to standing or if you haven't eaten or for no apparent reason

Is this dizziness vertigo ie. the room spins or just light headedness?....
.....
.....

Have you ever fainted before?.....

Do you ever feel unwell, sick or faint at the sight of blood or needles?
.....

Have you ever felt unwell or dizzy after a neck manipulation from a manipulative therapist or felt unwell in any way after treatment?.....
.....

Do you often pull up sore after treatment?.....

Have you ever suffered any seizures? Yes/No

If yes, please specify:

Do you at times find it difficult to breath? Yes/No/ Sometimes

Do you suffer shortness of breath?.....

Menstrual Cycle

Do you suffer from period pain?or lose clots or hold fluid in the breasts, belly, etc. prior to a period?

For how many days do you have your period? How many days between periods?

Are your periods regular?.....

List any premenstrual symptoms you experience.....
.....
.....

Have you had a hysterectomy? Yes /No

Have you ever taken the oral contraceptive pill? Yes /No

If so, for how long?
.....

Diet and Habits

State the number of cups of tea you drink per day and number of sugars per cup: Tea Sugars per cup

State the number of cups of coffee you drink per day: Coffee Sugars per cup

Please list your diet on an average day

Breakfast

.....

Morning Tea

Lunch

.....

Afternoon Tea

Evening Meal

.....

Dessert.....

Beverages other than tea or coffee, e.g. soft drinks, milk, etc.

.....

How often and how much do you eat cakes, sweets, chocolates, biscuits or take-away food?

.....

.....

Do these foods disagree with you? Yes/No

If yes, please specify the foods that do not agree with you and the symptoms you suffer:

.....

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Other issues not covered.....

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Please read this consent form. We will discuss it together and it needs to be signed in the office.

INFORMED CONSENT

Client's Name

Client's Address D.O.B:

Parent / legal guardian's name (if client below 18 yrs of age)

.....

Address Ph:

Osteopathy, Naturopathy and Acupuncture are recognised as effective and safe methods of health care for many conditions.

It is important, however, to recognise that there are risks associated with all methods of health care, to which all clients should be informed. These symptoms include, though are not limited to, aggravation of the pre existing condition, nausea and dizziness after treatment, a bruise or bleeding at the site of acupuncture needle insertion, fractures, disc injuries, strokes (or like episodes), strains from the treatment, fainting with needles/Acupuncture.

Please read the text below carefully and ask questions if any of the information below needs to be clarified.

I understand, that Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic 9 Izett Street Prahran will be performing the assessment and treatment. I have disclosed all information asked by the practitioner(s) regarding my / my child's present and past state of health.

I acknowledge that I have had the opportunity to discuss the proposed care of mine / my child with the practitioner and that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care, and that I have been given sufficient time to make a decision giving the consent for the care to proceed.

I acknowledge that I have discussed with Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic the risks associated with my / my child's proposed care which may include an exacerbation and / or aggravation of my / my child's underlying condition. I also acknowledge that the following additional potential risks insofar as my / my child's proposed care is concerned have been explained to me.

Applicable / Not applicable

.....
I have discussed with Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic the range of techniques which he will use which include High velocity joint Manipulation, Targeted Massage, Stretching, Resisted Muscle Exercises, Acupuncture, the use of vitamin and mineral and herbal remedies, Osteopathy in the Cranial Field, Balanced Membranous Tension, Balanced Ligamentous Tension, and Fascial Release Techniques. Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic has explained to me, that in the case of cranial techniques that they use minimal or no force at all, and that they have been used safely with young infants, children and adults since the 1930ties.

.....
I acknowledge that I am aware of and understand the potential risks and appreciate that results cannot be guaranteed.

I do not except Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic to be able to anticipate all potential risks and complications associated with my / my child's proposed care.

I hereby acknowledge my consent to the performance of the proposed care as outlined to me by Dr. Michael Rowan or any other practitioner working in the Prahran Osteopathic Clinic. I understand that I can withdraw my consent at any time.

Signed Printed name.....Date

Patient / Legal Guardian Witness Name.....

Vascular Complications of Cervical Manipulation

- I. **References**
 - "The safety of manipulative treatment: review of the literature from 1925 to 1993", Vick et al, *JAOA*, February 1996.
 - "VBA stroke as a complication of cervical manipulation", Teasell and Marchuk, *Critical Reviews in PM&R*, 6(1):121-129(94).
 - "Complications of spinal manipulation: a comprehensive review of the literature", Assendelft et al, *Journal of Family Practice*, May 1996.
- II. **Incidence**
 - >90 million manipulations/year in U.S.
 - 1947-1996 --- 165 cases

 - Swiss Society for Manual Medicine (SAMM) survey:
203 physicians
1/40,000 slight complication (neuro)
1/400,000 stroke
- III. **Mechanism**
 - All were associated with upper cervical spine manipulation
 - All had combination of hyperextension with rotation to barrier, most with traction
- IV. **Predisposing Factors**
 - Average age --- 37 years
 - Implication is hypermobility
 - Not firmly associated with osteophytes
- V. **Contraindications**
- VI. **Conclusion**
 - Proper history
 - Know contraindications
 - Avoid hyperextension with hyperrotation (ANY procedure)

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Some Contraindications for Local Application of Direct Action Osteopathic Manipulative Treatment Techniques

1. Vascular insufficiency cervical spine
2. Severe arthritis of cervical spine (especially rheumatoid arthritis)
3. Acute cervical sprain/strain (whiplash)
4. Acute fracture (traumatic or pathologic)
5. Severe and brittle osteoporosis
6. Primary tumor of bone
7. Cancer metastatic to bone
8. Acute herniated nucleus pulposus within 72 hours of onset
9. Acute onset of dizziness/vertigo (prior to work-up)
10. Anticoagulation therapy/bleeding disorder
11. Osteomyelitis, disk infection or abscess
12. Ocular lens implant (first six weeks post-op)
13. Retinal detachment/tear
14. Acute cerebrovascular accident
15. Down's Syndrome
16. Hypermobility Syndromes (e.g. Ehlers-Danlos)
17. Metabolic bone diseases

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