Confidential Patient Information

CHIRO4FAMILY WELLNESS
Family Healthcare Naturally

Personal Information

Who may we thank for referring you?		
Full Name:		Date:
Address:		Postcode:
Home Phone:	Mobile:	Work:
Email Address:		
Date of Birth:	Occupation:	
Marital Status: M S W D	Partners Name:	Pregnant? YesNo
Names and ages of children		
Private Health Fund:		
Doctors Name & Address:		

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, Please skip to the "General Health History"

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1					
2					
3					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started, is it: About the same? Getting better? Getting worse? What have you done for this condition? Was it of benefit?

_____

_____

Which activities aggravate your condition?

_____

What makes your condition feel better? _____

Other doctors you have seen for this condition: _____

Is this condition interfering with any of the following?

Work Sleep Daily routine Sport/exercise Other (please explain):

General Health History

Have you had any surgery? (Please include all surgery)

1	When?
2	When?
3	When?

Have you had any accidents and/or injuries; auto, work-related, or other?
(Especially those related to your present problems).

1 Type	When?	Hospitalized? Yes No
2 Type	When?	Hospitalized? Yes No
3 Type	When?	Hospitalized? Yes No

Have you ever had x-rays taken?

Area of body?	When?	Where?

Do you wear orthotics or heel lifts? Yes No

Past Health History

Please mark the following conditions you may have had or have now (- have had or + have now)

Alcoholism	Allergy	Arteriosclerosis	Arthritis
Asthma	Back Pain	Cancer	Cold Sores
Constipation	Convulsions	Depression	Diabetes
Diarrhoea	Eczema	Emphysema	Epilepsy
Gall Bladder Problems	Gout	Headaches	Heart Attack
Heart Disease	High Blood Pressure	HIV (Aids)	Irregular Periods
Low Blood Sugar	Malaria	Measles	Menstrual Cramps
Migraines	Miscarriage	Multiple Sclerosis	Sinus Problems
Neck Pain	Nervousness/Anxiety	Irritable Bowel Syndrome	Pleurisy
Pneumonia	Polio	Rheumatic Fever	Ringing in ears
Stroke	Thyroid Problems	PMS	Ulcers
Venereal Disease	Whooping Cough	Other _____	

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

Are you interested in knowing more about how your nutrition affects your overall health and well-being? _____

If dietary changes are indicated would you be willing to make changes in your diet? _____

Would you take whole food supplements if indicated? _____

If specific exercises or stretching would help would you consider adding them to your program? _____

If reducing stress would help you, would you like to know ways to reduce stress? _____

Stressors

Stress affects our health and ability to heal. Please list your top 3 stresses (you have ever had) in each category:

Physical Stress (falls, accidents, work posturers, etc)

1 _____

2 _____

3 _____

Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc)

1 _____

2 _____

3 _____

Psychological or mental/emotional stress (work relationships, finances, self-esteem, etc)

1 _____

2 _____

3 _____

On a scale of 1-10, please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional)

At work _____ At home _____ At play _____

How do you grade your physical health?

Excellent	Good	Fair	Poor	Getting better	Getting worse

How do you grade your emotional/mental health?

Excellent	Good	Fair	Poor	Getting better	Getting worse

_____ _____

Patient's Signature Date

Chiropractor's History **(To be filled out by Practitioner)**

_____

_____

_____

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Chiro 4 Family Wellness - Consent to Chiropractic Care

Chiropractic care is recognized as being an effective and safe modality of care for both adults and children. However, as with all health care procedures there is a health risk which you are required to be informed about. This is not meant to frighten you it is simply to make you better informed.

The risks of a child experiencing an adverse reaction to chiropractic care is extremely rare and has been estimated at between 1 in 250 million and 1 in 700 million chiropractic adjustments.

In adults chiropractic care is also a very safe form of health care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know.

Please read the following carefully:

- ☐ I acknowledge that I have discussed with the treating Chiropractor the rare risks associated with my / my child's proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my / my child's underlying condition.
- ☐ I also acknowledge the following additional potential risks insofar as my / my child's proposed care is concerned have been explained to me.
- ☐ I have also had the opportunity to discuss the proposed care with the treating Chiropractor and 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. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
- ☐ I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- ☐ I hereby acknowledge my consent to the performance of the proposed chiropractic care by and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

Adult

. ..... ……

Patients signature Patients Name (printed)

Child / Minor (parent or guardian if patient is under 18)

……. …….. …… ….

Parents' signature Childs name (printed) Dated

Office Use Only (To be completed by DC or CA)

…… ……

Witness to patient's signature Dated

Privacy Statement

This practice collects your personal information to assist us in providing a service to you. We recognize and support your right to privacy in relation to this information.

Please tick if you do not agree to the following:

- ☐ To a 'thank-you letter' being sent to the person who referred you to us.
- ☐ To your name being added to our referral board when you refer a new patient to