



Date: ____/____/____

NEW CLIENT CHIROPRACTIC

Mr Mrs Ms Dr Full name: _____

Address: _____ Suburb & Postcode: _____

Phone (H): _____ (M): _____ (W): _____

DOB: ____/____/____ Email: _____

Marital status M W S D Partners name: _____

In case of emergency please contact: _____ on: _____

Pregnant: Y/N Weeks: ____/40 Name/ages of children: _____

Occupation: _____ How did you hear about us? _____

Sports, hobbies or regular activities: _____

GP Name: _____ GP Address: _____

GP Phone: _____ Health fund: _____

Have you ever experienced chiropractic care? Yes No

Do you smoke? Yes No Do you maintain a healthy diet? Yes No

Are you on any regular or temporary medication at the moment? Please explain: _____

Do you sleep on your: Side Back Stomach? How many pillows do you use? _____

What type of mattress do you use: Soft Medium Firm?

What are your personal healthgoals? _____

Have you been affected by any of the following? Please tick.

Allergies: (Please specify) _____

- | | | | |
|--|---|--|--|
| <input type="radio"/> Anxiety | <input type="radio"/> Arthritis | <input type="radio"/> Asthma | <input type="radio"/> Attention Deficit Disorder |
| <input type="radio"/> Been hospitalised | <input type="radio"/> Cancer | <input type="radio"/> Chronic Fatigue | <input type="radio"/> Depression |
| <input type="radio"/> Diabetes | <input type="radio"/> Dizziness | <input type="radio"/> Ear Disorders | <input type="radio"/> Epilepsy |
| <input type="radio"/> Fractured/Broken a Bone | <input type="radio"/> Headaches | <input type="radio"/> Heart Trouble | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Infertility | <input type="radio"/> Knocked Unconscious | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Menstrual Disorders |
| <input type="radio"/> Motor Vehicle Accidents | <input type="radio"/> Numbness/Pain in Arms/Hands/Legs/Feet | <input type="radio"/> Poor Circulation | <input type="radio"/> Stroke |
| <input type="radio"/> Recurrent Sore Throat | <input type="radio"/> Sinus Trouble | <input type="radio"/> Sleeping Problems | <input type="radio"/> Stroke |
| <input type="radio"/> Treated for a Nerve/Spine Disorder | <input type="radio"/> Urinary Disorders | <input type="radio"/> Varicose Veins | |

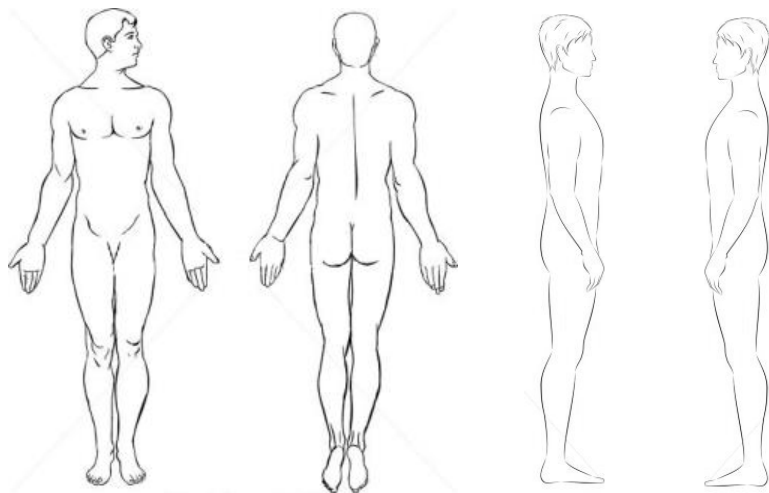
Any other concerns: _____

Reason for Chiropractic Care: _____

How long has this been a concern? _____

On a scale of 1 to 10 what is your rate of pain? _____

Please illustrate areas of complaint:



Client consent:

At A.C.E. Wellness we aim to provide the highest Quality 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. The risk is currently estimated at 1 in 1,000,000 for stroke and stroke like symptoms. This is a rare, random 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 the risk is minimised through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know.

I acknowledge that I have read the consent to chiropractic care and understand that if at any time I have concerns they can be discussed with my chiropractor. I appreciate that I will receive the best care possible at A.C.E. Wellness but that results can not be guaranteed.

I understand my client information is confidential, however A.C.E. Wellness may need to correspond with various third parties, including GP, Specialist or Insurance Companies.

I give permission for A.C.E. Wellness to release my information for this purpose. I also give permission for my photograph to be taken by A.C.E. Wellness for the sole purpose of being added to my client file for security reasons.

Client Signature: _____ Date: ____/____/____ CA Signature _____

A.C.E. Wellness provides a SMS service to remind you of your appointments. All clients are automatically enrolled in this service. If you do not wish to have this service, please indicate below:

Please do not send me SMS reminders for my appointments.



PAYMENT OF ACCOUNTS

Thank you for choosing A.C.E. Wellness as your specialised wellness centre. We recommend that you read the following information concerning payment of your account. At A.C.E. Wellness, we pride ourselves on the relationships we have between ourselves and our clients.

The trust we have between our clients and ourselves is paramount in the provision of treatment for you. For this reason, we ask you to always provide us with the most up to date information concerning your address, contact details and status of your claim.

Liability for payment of your account for treatment always rests with you as the recipient of our services here at A.C.E. Wellness. This also includes the situation where the insurer or other organisation or body nominated by you declines to pay for any reason.

If you are pursuing a Workers Compensation, Motor Accident claim or other legal proceedings arising from the injuries for which we are treating and the relevant insurer has accepted liability for medical treatment, then you should inform us without delay and provide us with the relevant documents specifying the insurer and claim number. A.C.E. Wellness can then forward accounts directly to the insurer for payment.

If however the insurer declines to pay such medical payments, or ceases paying during treatment, then you are liable for payment. As a matter of course however, if you are proceeding with a claim you should forward these paid accounts to your solicitor so they can be included in your claim and reimbursed to you at the end of proceedings.

Regrettably A.C.E. Wellness can not continue to provide services to you for accounts remaining in arrears for longer than 28 days, after which time A.C.E. Wellness also reserves the right to claim interest at the rate of 10% per day.

Please note that a cancellation fee of \$25.00 will apply for any cancellations where less than 5 hours notice has been provided.

The team at A.C.E. Wellness look forward to continuing to strive to provide you with the best services available. Should you at any time have any questions concerning our account practices, please don't hesitate to contact us.

The above statements are not meant to cause offence, but have to be included to comply with the legal requirements concerning the provision of billing information. Please note that the outstanding accounts will be reported to the National Debt Default Register. This will affect future credit applications.

I acknowledge that I have been informed of the Payment of Accounts procedures at A.C.E. Wellness and agree and comply with these.

Signed: _____ Date: ___/___/___ CA Signature: _____