Date: ____/____/____

REVIEW CLIENT CHIROPRACTIC

3years+

Mr O Mrs O Ms O Dr O 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: ___________________ Sports, hobbies or regular activities: ___________________

GP Name: __________________ GP Address: ____

GP Phone: ____________________________ Health fund: ________________________________

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

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

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

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

____

Have you had any re-occurrence of your former problems? O Yes O No If yes, please explain:

____

Have you had any new problems? O Yes O No If yes, please explain:

____

Have you had any accidents, falls or injuries since your last visit? O Yes O No
If yes, please explain:

____

Have you had any illness? O Yes O No If yes, please explain:

____

Have you had any surgery? O Yes O No If yes, please explain:

____

Have you consulted another doctor for any of these problems? O Yes O No If yes, please explain:

____

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

O Allergies: (Please specify) ____

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

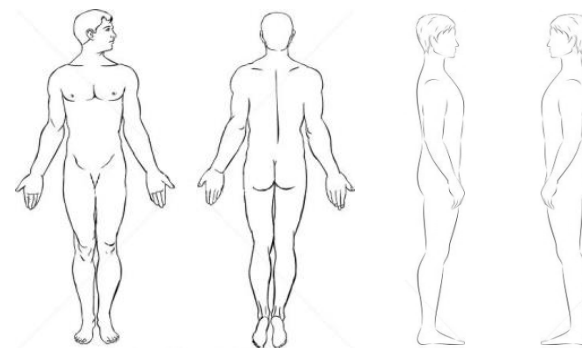
O Any other concerns: ____

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:

O 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 you 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: ________________________