MINDARIE KEYS CHIROPRACTIC & WELLNESS CENTRE

PERSONAL AND FAMILY HISTORY

Name: _____ Today's Date: _____ Date of Birth: _____

Address: _____ Sex: ☐ F ☐ M Private Health Fund: _____

Suburb: _____ Postcode: _____ Are you or might you be pregnant? ☐ Yes ☐ No

Phone: _____ Occupation: _____

Emergency Contact Name and Number: _____ Spouse's Name: _____

_____ Age of Children: _____

Email: _____ **Referred By:** _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Present Complaint (Reason for your visit today): _____

Pain or problem started how and when? _____

What activities make your condition/pain worse? _____

What activities make your condition/pain better? _____

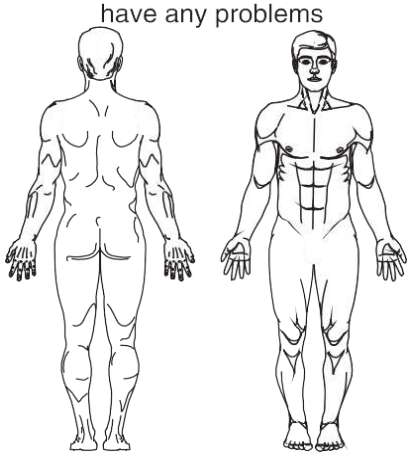
If you have pain, is it… ☐ sharp ☐ dull ☐ radiating ☐ burning
☐ mild ☐ moderate ☐ mod-severe ☐ severe
☐ constant ☐ intermittent

Since it began, is it… ☐ the same ☐ variable ☐ getting better ☐ getting worse

Does it interfere with…. ☐ work ☐ sleep ☐ walking
☐ sitting ☐ exercise ☐ other _____

Are there other doctors/treatments that you have tried for this problem? (Please tick)
☐ massage therapist ☐ physiotherapist
☐ acupuncturist ☐ medical doctor
☐ other _____ ☐ chiropractor, if so who _____

Circle/mark the areas where you have any problems



FAMILY HEALTH PROFILE - Please mark if you have a family history of:

	Arthritis	Cancer	Diabetes	Heart Disease	High Blood Pressure	Strokes	Other _____
Your father's side	☐	☐	☐	☐	☐	☐	☐ _____
Your mother's side	☐	☐	☐	☐	☐	☐	☐ _____
Your children	☐	☐	☐	☐	☐	☐	☐ _____

MEDICAL INFO: Who is your medical doctor? _____

If you are taking medications, please list them

MED: _____ For what? _____ For how long? _____

MED: _____ For what? _____ For how long? _____

MED: _____ For what? _____ For how long? _____

OTHER:

If you have had any surgeries, please list them

Surgery/Purpose: _____ Date: _____

Surgery/Purpose: _____ Date: _____

Surgery/Purpose: _____ Date: _____

TRAUMA & INJURIES

Did you ever….		If yes, please explain
Have any personal injury or accident?	Y / N	_____
Have recurrent childhood illness/sickness?	Y / N	_____
Experience other serious traumas/stress?	Y / N	_____
Have any mental or emotional disorders?	Y / N	_____
Suffer any concussions?	Y / N	_____

OTHER HEALTH HABITS

Do you…

Eat healthy foods regularly?	Y / N	Have high mental stress?	Y / N
Drink 8-10 cups of water per day?	Y / N	Have high physical stress	Y / N
Exercises regularly?	Y / N	Have sleeping problems?	Y / N
Smoke?	Y / N	Sleeping position: side, stomach, back	
Take vitamins or supplements?	Y / N	_____	

CURRENT SYMPTOMS (even if they do not seem related to your current condition)

☐ headaches / migraines	☐ dizziness / vertigo	☐ sinus problems / allergies	☐ high blood pressure
☐ neck stiffness / pain	☐ fatigue	☐ shortness of breath	☐ heart problems / stroke
☐ shoulder stiffness / pain	☐ snoring / sleep apnea	☐ constipation / diarrhea	☐ cancer
☐ pins and needles in arms	☐ tension / stress	☐ problems urinating	☐ diabetes
☐ numbness in fingers	☐ nervousness / anxiety	☐ cold sweats	☐ recurring infections
☐ back stiffness / pain	☐ irritability / mood swings	☐ hot flushes	☐ loss of smell / taste
☐ numbness in feet / toes	☐ depression	☐ menopause	☐ vision changes
☐ foot problems	☐ stomach upset	☐ PMS / menstrual cramps	☐ buzzing / ringing in ears
☐ jaw / TMJ problems	☐ heartburn / reflux	☐ infertility / impotence	☐ loss of balance
☐ chest pains	☐ ulcers	☐ cold hands / feet	☐ other: _____

RESULTS:

As a result of my chiropractic care, I would like to achieve: (tick all boxes that apply)

☐ Relief care ☐ Corrective care ☐ Wellness care

PLEASE NOTE:

Payment on the day by Cash or Eftpos only.
A $50 missed appointment fee applies if less than 8 hours' notice is given.
Declaration: I am responsible for full payment of my account after each treatment.

Signed: _____ Date: _____

I understand this clinic functions on a pay as you go basis and I am financially obligated for any fees, with the understanding this clinic will gladly prepare forms and reports if necessary to enable me to regain reimbursement from insurance companies. (You can have/keep all x-rays upon request as long as your current account is paid in full: however, 24 hours' notice is required)

GOALS & CONSENT

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential.

Consent to Evaluation

I …… hereby grant permission to receive a chiropractic evaluation including history, examination and x-rays if required. Any findings will be communication before consenting to commencement of care, if appropriate.

Signed: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE:

Chiropractors and other practitioners who use adjustments are now required legally to advise patients with spinal problems the following:
Over the years there have been rare incidents of injury to the vertebral artery during the course of neck adjustments. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chance of this happening are 1 in 115 million.
Other very slight risks with treatment include sore muscles, headache and disc injuries. With these incidents, a full recovery is anticipated.

If you have any further questions regarding this matter, please ask your Chiropractor.

I have read the above statement and consent to treatment. Signed: _____ Date: _____

We all, on a daily basis experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. These effects can be hardly noticed until they become serious. Our Chiropractors pride themselves on finding and correcting the cause, not treating the symptoms.