MINDARIE KEYS CHIROPRACTIC & WELLNESS CENTRE

Please Print Clearly and fill in both sides completely

Print Name _____ Email _____

Address _____

Suburb _____ State _____ Postcode _____ Date of Birth _____ Age _____

Phone (Hm) _____ (Wk) _____ (Mob) _____

Please tick ✓ Sex: Male ☐ Female ☐ Married ☐ Single ☐ Other ☐

Where did you hear about our clinic / who referred you? _____

Your Occupation _____ Do you primarily ☐ sit ☐ stand ☐ lift ☐ perform repetitive tasks

Next of Kin - Name _____ Contact number _____

Children(s) Name(s) & Ages _____

Which private health fund are you currently with? _____

Wellness Profile

Do you have a specific concern that brought you in?

☐ No. I'm interested in having my nervous system assessed to achieve optimal health and functioning.

☐ Yes. _____

If yes, please answer the following questions:

What is your primary area of complaint today?

_____

Are you under the care of any doctors or specialists? ☐ Yes ☐ No

If yes, the condition being treated for : _____

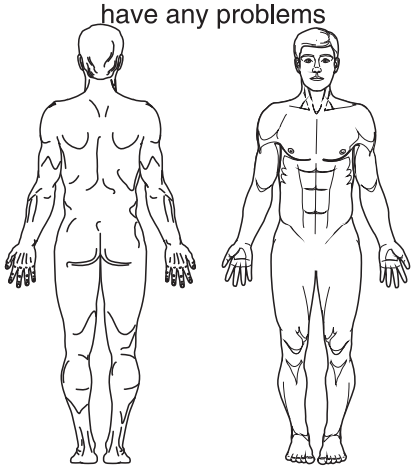
Who is your GP? _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

Circle/mark the areas where you have any problems



FEMALES: Please Tick One ✓ Is there a possibility of you being pregnant? Yes ☐ No ☐

How old is your current mattress? _____ Pillow _____ (Spring ☐ Latex ☐ Water ☐)

Chiropractic History

Have you ever been to a Chiropractor before? Yes ☐ No ☐ If yes, Doctor's Name _____

Date of last Chiropractic visit? _____ Reason for care? _____

Date of last chiropractic x-rays or other _____ How long were you under their care? _____

Are you seeking chiropractic care today for:

☐ Relief Care - Symptom relief of pain or discomfort
☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
☐ Wellness Care - Maximising the body's ability for optimal healing and function of the nervous system

Wellness Commitment

We are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100% please circle your personal level of commitment toward obtaining and maintaining health and awareness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Please Fill in Below

If you have had the following, or if you suffer from the following, Please Tick ✓

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches Migraines	☐ ☐	☐ ☐
Neck Pain Shoulder Pain	☐ ☐	☐ ☐
Arm/Hand Pain Mid Back Pain	☐ ☐	☐ ☐
Low back Pain Hip Pain	☐ ☐	☐ ☐
Leg/Foot Pain Disc Problems	☐ ☐	☐ ☐
Arthritis Other Joint Pain	☐ ☐	☐ ☐
Numbness Joint Swelling	☐ ☐	☐ ☐
Dizziness Nausea	☐ ☐	☐ ☐
Weakness Fatigue	☐ ☐	☐ ☐
Nervousness Insomnia	☐ ☐	☐ ☐
Heart Problems Vision Changes	☐ ☐	☐ ☐
Nose Bleeds Ringing in Ears	☐ ☐	☐ ☐
Earaches Hearing Loss	☐ ☐	☐ ☐
Cough Chest Pains	☐ ☐	☐ ☐
Female Problems Allergies	☐ ☐	☐ ☐
Asthma Cancer	☐ ☐	☐ ☐
Osteoporosis Diabetes	☐ ☐	☐ ☐
Hypoglycemia Digestive Problems	☐ ☐	☐ ☐
Urinary Problems Frequent Colds	☐ ☐	☐ ☐
Skin Conditions Other _____	☐ ☐	☐ ☐

Below, please fill in any other health information you might feel we need for your care.

_____

_____

_____

_____

_____

Please Note:

- Payment on the day by Cash or Eftpos only.
- A $50 missed appointment fee applies if less than 24 hours notice is given.
- This office does not bill Insurance companies direct.

Declaration:

I am responsible for full payment of my account after each treatment. If an account remains unpaid, I will be responsible for all collection, interest and administration fees.

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 account is paid in full: however - twenty four (24) hours notice is required.)

We may contact you as a follow up on your treatment. If you are not available you consent to us leaving a message on the message service of your contact numbers advising that we called.

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. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I.....hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

INFORMED CONSENT TO CHIROPRACTIC CARE

Chiropractors and other practitioners who use adjustments (manipulation) are now required legally to advise patients with spinal problems of 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 chances of this happening are **1 in 1-1.5 million**. There is more chance of your being hit by lightning.

Other very slight risks with treatment include muscle strains and disc injuries. With these incidents a full recovery is anticipated.

Further diagnostic tests such as the surface EMG, with or without x-rays may be performed on yourself to further minimise any risk.

Chiropractic is considered to be the safest and most effective form of treatment for your problem. No person in Australia has died from a chiropractic adjustment.

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

I have read the above statement and consent to treatment.

Signed the Patient.....

Print Name Here.....

Dated / /