



**Personal Details:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

**Website membership:**

*I would like to become a member of the Cannon Hill Family Chiropractic Centre website:*

Yes  No

*By joining our website, you authorise us to send occasional health emails to you. Naturally you can opt out at any time.*

**Emergency Contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**General Details:**

*Primary reason for consulting our clinic:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*How long has this been going on? Days: \_\_\_\_\_ Months: \_\_\_\_\_ Years: \_\_\_\_\_*

*Any other warning signs or complaints?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Any previous accidents/incidents in your life?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Have you seen other Chiropractors:  Yes  No*

*If yes, what was the name of the Chiropractor? \_\_\_\_\_*

*Name of medical doctor (GP): \_\_\_\_\_*

*Anyone else seen for this complaint: \_\_\_\_\_*

*Do you consent to our Practitioners contacting other Medical or Allied Health Professionals regarding your care if necessary?  Yes  No*



**Injury History:**

Have you broken any bones? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you had a concussion? Please describe: \_\_\_\_\_

\_\_\_\_\_

Have you been involved in a motor vehicle accident? Please describe: \_\_\_\_\_

\_\_\_\_\_

Please list any surgeries you have had: \_\_\_\_\_

\_\_\_\_\_

List any current medications/supplements: \_\_\_\_\_

\_\_\_\_\_

Current Health Challenge Information				
Describe the pain:	<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull	<input type="checkbox"/> Travels	<input type="checkbox"/> Constant
Since the onset, is the pain:	<input type="checkbox"/> Worse	<input type="checkbox"/> Better	<input type="checkbox"/> The same	<input type="checkbox"/> On & Off
Do any of these make it worse:	<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Lying	<input type="checkbox"/> Motion
Are any systems involved:	<input type="checkbox"/> Digestive	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Cardiovascular
Does the pain cause you to:	<input type="checkbox"/> Lose Sleep	<input type="checkbox"/> Be short tempered	<input type="checkbox"/> Miss work/Play	<input type="checkbox"/> Lose Focus

Please check all warning signs even if not seemingly related to your complaint at the moment.		
<input type="checkbox"/> Poor Attention	<input type="checkbox"/> Migraines	<input type="checkbox"/> Cold Hands
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Headaches	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Easily Distracted	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tight Muscles
<input type="checkbox"/> Disorganised	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Teeth Grinding
<input type="checkbox"/> Depressed	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Lacking Motivation	<input type="checkbox"/> PMS	<input type="checkbox"/> Heart Palpations
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Spaciness	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Poor Expression of Emotion
<input type="checkbox"/> Constipation	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Poor Immune System
<input type="checkbox"/> Low Pain Threshold	<input type="checkbox"/> Bi-Polar Disorders	<input type="checkbox"/> Racing Mind
<input type="checkbox"/> Difficulty Waking	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Worry	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Accelerated Aging
<input type="checkbox"/> Irritable	<input type="checkbox"/> Low Energy	<input type="checkbox"/> Irritable Bowel

*The information provided on this form is accurate, to the best of my recollection, and I agree to allow the practitioner to do an examination of me for further evaluation.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. In fact, the tonal treatments used by the chiropractors at Cannon Hill Family Chiropractic Centre have never been associated with any severe adverse reactions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully:-

1. I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

.....  
 3. I have had the opportunity to discuss the proposed care with my chiropractor. 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.

4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by my chiropractor and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

7. In very rare circumstances, some manual treatments of the neck may be associated with stroke or related symptoms (eg between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (eg less than 1 in 139,000) and the low back (eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

.....  
Patient Signature  
(Parent or Guardian to also sign if patient is under 18)

.....  
Chiropractor Signature

.....  
Patient Name (printed)

.....  
Chiropractor Name

Dated:.....

## CONSENT REGARDING PRIVACY

Cannon Hill Family Chiropractic Centre, needs to collect information about you for the primary purpose of providing quality service to you. In order to thoroughly assess, diagnose and provide chiropractic services, we need to collect some personal information from you. If you do not provide this information; we may be unable to provide care to you. This information will be used for:

- The administrative purpose of running the practice.
- Billing either directly or through an insurer or compensation agency.
- Use within the practice if discussing or passing your case to another practitioner within the practice for your ongoing management.
- Disclosure of information to your doctors, other health professionals or professionals to facilitate communication and best possible care for you.
- In case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your company.

We do not disclose your personal information to overseas recipients.

Cannon Hill Family Chiropractic Centre has a Privacy Policy that is available on request and is available in the Reception Area. That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include ( but not limited to) your doctor, teachers, specialists, insurers, solicitors or employers.

I, (Name) \_\_\_\_\_, have read the above information and understood the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interest of my assessment and healthcare progress.

I am aware that I can access my personal and treatment information on request and if necessary, correct information that I believe to be inaccurate.

I understand that if, in accordance with the exceptions contained in the Act, access is denied for legitimate purposes, that the reason for this and possible remedies will be made available to me.

I have been provided with or have been given an opportunity to obtain a copy of Cannon Hill Family Chiropractic Centre's Privacy Policy.

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_