Cannon Hill Family Chiropractic Centre – Patient paperwork

CANNON HILL FAMILY CHIROPRACTIC CENTRE

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Name: _____ M: _____

W: _____

Referred by: _____ Ph: _____

Is this for the whole family? ☐ Family ☐ Self Family Members: _____

Primary reason for consulting our office: _____

Any other warning signs, complaints? _____

How long has this been going on? Days: ____ Months: _____ Years: _____

Any previous incidents in your life? _____

GENERAL INFORMATION

Address: _____

Suburb _____ Postcode: _____

Occupation: _____ DOB: _____ Age: _____

Seen other Chiropractors: ☐ Yes ☐ No Who: _____ No. of Visits: _____

X-Rays in last two years: ☐ Yes ☐ No

Name of Medical Doctor: _____ Others seen for this condition: _____

Our Practice communicates with other medical and Allied Health Practitioners relating to your care. Do you consent? ☐ Yes ☐ No

Name: **Date:**

Signature:

Email: _____

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 related emails to you. Naturally you can opt out at any time.

Emergency Contact Details:
Name:
Relationship to you
Contact Phone Number

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Health Review

Current Health Challenge Information

Describe the pain:	Sharp □	Dull □	Travels □	Constant□
Since the onset is the pain:	Worse □	Better □	The same □	On & off□
Is there anything that makes it worse:	Standing □	Sitting□	Lying□	Motion □
Are any systems involved:	Digestive □	Cardiovascular□	Respiratory □	Elimination □
	Reproductive □			
Does the pain cause you to:	Lose sleep □	Be short tempered□	Miss work □	Miss play □
	Lose focus □			

Any other facts about your current problem or pain:

Please check all your warning signs even if not seemingly related to your complaint at this moment.

1.	2.	3.
□ Poor Attention	□ Migraines	□ Cold hands
□ Impulsive	□ Headaches	□ Cold feet
□ Easily distracted	□ Seizures	□ Tight muscles
□ Disorganised	□ Sleepwalking	□ Teeth grinding
□ Depressed	□ Hot Flushes	□ Anxiety
□ Lacking Motivation	□ PMS	□ Heart palpitations
□ Poor Concentration	□ Food sensitivities	□ Restless sleep
□ Spaciness	□ Bed wetting	□ Poor expression of emotion
□ Constipation	□ Eating Disorders	□ Poor immune system
□ Low pain threshold	□ Bi-polar disorders	□ Racing mind
□ Difficulty waking	□ Mood swings	□ High blood pressure
□ Worry	□ Panic attacks	□ Accelerated aging
□ Irritable		□ Irritable bowel
□ Low energy		

Injury History

Hospital birth: Yes □ No □ Play any sport? Yes □ No □ What Sport: _____

Ever broken a bone?_____ Did you fall as a child? Yes □ No □

Ever been knocked out? Yes □ No □ Ever been in any motor vehicle accidents?

(please note type & year, even if not apparently injured)

Any surgeries?

History of Illness: list any current medications:

Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office 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:_____