Cannon Hill Family Chiropractic Centre
Patient History

☐ 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 conscent? ☐ 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

Please indicate topics of interest:

☐ Headaches and Neck Pain ☐ Wellness Topics ☐ Backaches and Sciatica

☐ Diet and Nutrition ☐ Children's Health Issues ☐ Exercise and Fitness

☐ Women's Health Issues ☐ Stress Management

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

VISITS SCHEDULED

Visit 1 _____ **Visit 2** _____

Visit 3 _____

Visit 1: Full Health History, Quality of Life Assess, Neurological Exam, Orthopedic & Biomechanical Testing & Spinal Health Check.

Visit 2: Review and report of Diagostic testing plus first adjustment

Visit 3: Discovery Report and care plan - choice of care plan options

Cannon Hill Family Chiropractic Centre
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 FORM

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's Signature
(Parent or Guardian to also sign if patient is under 18)

Chiropractor's Signature

…… ……

Patient's Name (printed)

Chiropractor's Name

Dated:……

CANNON HILL FAMILY CHIROPRACTIC CENTRE
OFFICE POLICY

Welcome to Cannon Hill Family Chiropractic Centre.
Cannon Hill Family Chiropractic Centre is dedicated to inspiring HOPE through KAIZAN, to promote CELLULAR HARMONY with a focus on making improvements to LIFESTYLE that empowers individuals to experience their true potential.

COMMITMENT TO CARE:
At Cannon Hill Family Chiropractic Centre we believe that your healthcare is your responsibility. We will do our best to help you with your Chiropractic journey, but the commitment to care must be your priority, to allow the innate healing powers of your body to succeed.

ADJUSTMENT SCHEDULING:
To save time and give efficiency, we ask that all appointments are pre-scheduled. This patient scheduling allows us to offer you the days and times that you prefer to increase your healing powers. If an appointment is not pre-scheduled we can not guarantee times that are favorable to you.

RESCHEDULE CALL:
Should you miss your appointment, we will call within ½ an hour of the appointed time to reschedule with you. It is vital to maintain the recommended care plan therefore we will look for something in the same day, or next few days.

CANCELLED APPOINTMENTS:
Please notify the Office as soon as possible when unable to attend your appointment time. This allows the clinic to continue to run efficiently, and provide the highest care to all our patients.

FINANCIAL AGREEMENTS:
All office visits are to be settled at the time of the appointment.
To avoid misunderstandings, please inform us of any problem you may have in keeping your financial arrangements. Our Office Manager can be contacted to talk about the concerns you may have.

TRAINING & SEMINARS:
Our team prides itself on providing you the most up to date care. Therefore, from time to time we will be attending seminars, training and continue education programs. We will make available a chiropractor you can contact if required.

DISCOURAGEMENT:
Healing takes time. At any time if you are feeling discouraged please contact us to discuss your progress.

EDUCATION CLASSES:
To achieve optimum results while under care, education is very important. The Office will have classes to increase your awareness of many different areas of health. These classes, workshops or guest speakers will be advertised through out the office to give you plenty of notice, and allow you to attend. It is encouraged by our office to attend as many as you can as knowledge is the power in healing and optimum wellness.

PRIVACY POLICY:
Cannon Hill Family Chiropractic Centre is aware and adheres to the outlined Privacy Provisions. .
For further information contact the Office Manager.

I have read the Office Policy for Cannon Hill Family Chiropractic Centre and agree to the above outlined policies and agreements.
Signature:_____ **Printed Name:**_____ **Date:**_____

Cannon Hill Family Chiropractic Centre: Empowering individuals to experience their true potential.