# CHIROPRACTIC
# NEW PATIENT
# REGISTRATION FORM

Date: _____

1. Title: [Mr/Mrs/Miss/Ms] ☐☐☐☐ ☐ Male ☐ Female
2. Surname: _____
3. First Name: _____
4. Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐
5. Street Address: _____
   Suburb: _____ Post Code:
6. Telephone: (H) _____ (W) _____
   Mobile: _____
7. Email: Please provide your email address so we can keep in touch with you.
   _____
8. Marital Status: O Married O Defacto O Divorced O Single Number of children? _____
9. Emergency Contact: Name: _____ Ph: _____
10. GP Details: Name: _____ Ph: _____
    Address: _____
11. Do you give us permission to send a letter to your Doctor confirming that you have commenced Treatment? **Y** / **N**
12. **How did you find out about this practice?**

    ☐ Advert / Poster ☐ Brochure/ Flyer ☐ Yellow Pages ☐ Yellow Pages Online
    ☐ Directory Assist ☐ Our Website ☐ From My Doctor_____

    ☐ Friend Referral (name) _____
13. **Private Clients :- Do you have Private Health Insurance? Yes / No** (name)_____
14. **Do you have: -** ☐ Pensioner Card ☐ Student Card ☐ Health Care Card
15. **Veterans Affairs Clients :- Card Number** _____
16. **Do you have a Medicare EPC (Enhanced Primary Care) plan from your doctor? Yes / No**
17. **Are you claiming through Worker's Compensation, MVA or Insurance Commission?**
    ☐ **Yes [please complete WC/MVA form]**

## CONFIDENTIAL PATIENT CASE HISTORY

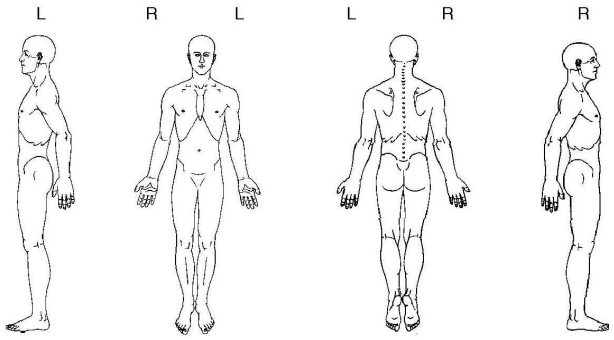
1. **What is the reason for seeking our services today?**_____
   _____
2. **If you have a painful condition, when and how did it begin**? _____
   _____

3. **What do you hope to achieve specifically from treatment? (Include goals and deadlines)**

_____

_____

4. **Draw on the sketch below the area where you feel your problem to be.**




| YOUR COMPLAINTS | SCORE OUT OF 10 |
|---|---|
| 1. | /10 |
| 2. | /10 |
| 3. | /10 |

5. **Lifestyle Stress** (*for us to best help you it is important to know about your general lifestyle to give recommendations on the best strategy for your health.*)

   Grade your stress (1 = minimum 10 = maximum) for the following
   Work/Study /10 Home life /10 Relationship /10 Play /10

6. Mark on the line:
   Eating habits: Poor ---------- Perfect
   Exercise habits: Poor ---------- Perfect
   Sleep: Poor ---------- ----------Perfect

7. Is your health recently: O Staying the same O Worsening O Improving

8. **How long have you had this problem?**

   _____

9. **Have you had this or a similar problem in the past?**

   _____

10. **If you are experiencing pain, please tick the words that best describe your pain:**

    ☐ Constant or ☐ Comes & goes ☐ Sharp or ☐ Dull Achy

    ☐ Intensity varies ☐ Intensity doesn't vary ☐ Shooting ☐ Radiates ☐ Travels

11. **Do you get?** ☐ Pins and needles ☐ Tingling ☐ Numbness ☐ Weakness

12. **Since the problem started, it is -** ☐ About the same ☐ Getting better ☐ Getting worse

13. **What makes your pain worse?**

    ☐ Sitting ☐ Standing up from a chair ☐ Walking ☐ Other……

14. **Your pain interferes with**:
    ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure

15. **What type of work do you do?** _____

16. **Other health professionals seen for this problem (please list):**

    ☐ Medical Doctor _____ ☐ Specialist Doctor/Surgeon_____

    ☐ Chiropractor _____ ☐ Physiotherapy _____

☐ Other _____

17. **Was there anything you were not happy about with your prior treatment?**

_____

18. **What aspects were you happy with?** _____

_____

19. **List any medications you are taking** _____

_____

20. **Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? Yes / No**

21. **Are you pregnant? ☐ Yes ☐ No ☐ N/A**

22. **Do you have or have you ever had?: (please tick)**

| | | |
|---|---|---|
| ☐ High blood pressure/Cholesterol | ☐ Energy loss / Fatigue | ☐ Cramps |
| ☐ Heart attack/problems | ☐ Cancer | ☐ Spinal surgery |
| ☐ Strokes | ☐ Osteoporosis | ☐ Dizziness |
| ☐ Constipation/Diarrhoea | ☐ Arthritis | ☐ Neck Pain |
| ☐ Diabetes | ☐ Headaches | ☐ Sinusitis |
| ☐ A pacemaker | ☐ Migraine | ☐ Thyroid problems |
| ☐ Car Accident, when _____ | ☐ Frequent infections | ☐ Heartburn |

## Clinic Policy

**Our goal** is to deliver an exceptionally friendly and prompt, professional service providing you with the best in chiropractic care. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the **greatest benefit** from our services.

**PRIVACY POLICY STATEMENT:** In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between practitioners within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

**Mobile Phones:** Out of respect for others, please turn off your mobile phone.

**Recovery:** Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected we would ask that you discuss this with your chiropractor. We want you to get the most from your care at our clinic.

**Excellence in Chiropractic:** In order to continue to provide the best, most up to date chiropractic care available we travel periodically to conferences and seminars. To keep your progress on schedule we will attempt to book your appointments around those times or else provide another highly qualified chiropractor to continue your care.

**Fees and Your Account:** Fees for private patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover and DVA patient accounts will be sent directly to the appropriate body. The account financial settlement ultimately still remains the responsibility of the patient.

**Referrals:** The greatest compliment we can receive is the referral of a friend or family member. The referral of your family and friends is much appreciated as it will both sets them on the road to recovery and wellbeing and plays a vital role in the success of our business. Please let us know the name of your referrer so we may thank them.

**Appointment Scheduling:** Your chiropractor will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

**Missed Appointments:** Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given for a cancellation, a cancellation fee may be charged. Consideration will be given for unavoidable circumstances. All missed appointments must be made up later in the same day or within 24 hours to avoid a cancellation fee. **This fee is not covered by compensable bodies and must be paid by the patient**. People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise we will not be able to help you reach your goals.

**Chiropractic Information**

Chiropractic care is recognised as being an effective and safe method of care for many conditions. 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 Chiropractic Doctors at The Wellness Place 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 in so far as my proposed care is concerned have been explained to me.

3. I have had the opportunity to discuss the proposed care with Chiropractic Doctors at The Wellness Place. 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 Chiropractic Doctors at The Wellness Place. I understand that I can withdraw consent at any time.

7. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** 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 (**current statistics** eg less than 1 in 139,000) and the low back (**current statistics** 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."*

**Questions of a personal nature:** Your practitioner may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the practitioner can provide effective treatment. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the practitioner know.

**Physical contact:** During the examination, assessment and treatment it may be necessary for the practitioner to make physical contact. Your practitioner will ask your permission before making physical contact with you in any way. Physical contact requires your express consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your practitioner if you feel uncomfortable at any time.

**Print Patient Name**: _____
*(Guardian name if patient under 18 years)*

**Patient Signature**: _____
*(Guardian signature if patient under 18 years)*

**Practitioner's Name and signature**: _____ **Date**: _____