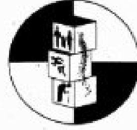


Confidential Patient Information

The information on this form is and will remain strictly confidential.

File No.(Office use only)

TODAY'S DATE: ……………………….

SURNAME: …………………………………………. GIVEN NAMES: …………………………………

ADDRESS: …………………………………………………………………………………………………

SUBURB: …………………………………… STATE: …………………… POSTCODE: ……………………

PHONE No. (Mobile): ……………………… (Home): ……………………… (Work): ………………………

DATE OF BIRTH: ……………………………… AGE: ………………

OCCUPATION: ………………………………… EMPLOYER: ……………………………………………

MARITAL STATUS: …………………………… NO. OF CHILDREN ………………………………

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? ………………………………………………

IF YES, WHAT WAS HIS/HER NAME? ………………………………………………………………

WHEN WAS YOUR LAST ADJUSTMENT? ……………………………………………………………

DID YOU HAVE X-RAYS TAKEN? ……………………………………………………………………

IF YES, HOW LONG AGO? ……………………………………………………………………………

IS THIS A WORK COVER CLAIM/TAC CLAIM? ………………………………………………………

IF YES, WHICH? ………………………………………………………………………………………

CLAIM NUMBER? ………………………………………………………………………………………

"IF LIABILITY FOR MY CLAIM IS DENIED, I UNDERTAKE TO PAY THE ENTIRE AMOUNT OF MY ACCOUNT AT THIS CLINIC"

Signed: ………………………………………….

HOW WERE YOU RECOMMENED TO OUR CLINIC?

FAMILY ☐ FRIEND☐ INTERNET ☐ SIGN ☐ YELLOW PAGES ☐ NEWSPAPER☐

IF FRIEND OR FAMILY MEMBER, PLEASE STATE NAME ………………………………………

REASON FOR SEEING CHIROPRACTOR TODAY ………………………………………………

LIST ANY PREVIOUS CAR ACCIDENTS, WHEN? INJURIES? ……………………………………

INJURIES/ACCIDENTS, WHEN? INJURIES? ……………………………………………………

EXERCISE PROGRAM/SPORTING ACTIVITIES? ………………………………………………

………

……………………………………………………………………………………

FEMALE: ARE YOU PREGNANT? YES ☐ NO ☐

OPERATIONS? …………………………………………………………………………………………

MEDICINE/DRUGS/VITAMINS – TYPE/DOSAGE ETC ……………………………………………

………

………

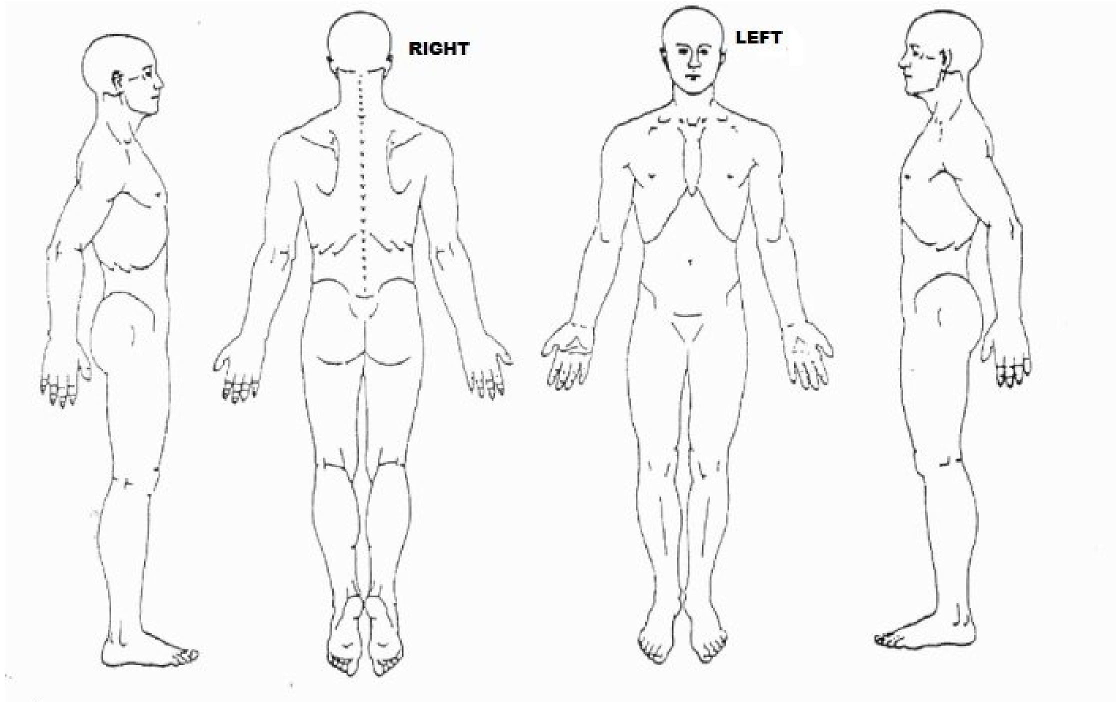
…………………………………………………………………………

Confidential Patient Questionnaire
The information on this form is and will remain strictly confidential.

Please tick the appropriate box if you currently have, or have ever had any problems with the following:

YES	NO		YES	NO	
☐	☐	Eyes	☐	☐	Injuring your body
☐	☐	Ears	☐	☐	Your mind
☐	☐	Nose	☐	☐	Sexual activity
☐	☐	Throat/Neck	☐	☐	Do you take medication?
☐	☐	Mouth	☐	☐	Do you take drugs socially?
☐	☐	Skin	☐	☐	Do you take any dietary supplement? (Vitamins, minerals , etc)
☐	☐	Abdomen/Digestion/Bowel	☐	☐	Have you ever been hospitalised?
☐	☐	Urination	☐	☐	If yes, was it for an operation?
☐	☐	Sexually Transmitted Disease	☐	☐	Do you drink any alcohol?
☐	☐	Chest/Lungs	☐	☐	Do you have a good appetite?
☐	☐	Heart	☐	☐	Does your weight change much?
☐	☐	Nervous System			
☐	☐	Joints			
☐	☐	Circulation			

Please indicate the location of your pain on these diagrams:



For each of your problems, please indicate the severity of pain by making a mark on the line:

No Pain Max pain

1. Problem area……………………… ________________________________
2. Problem area……………………… ________________________________
3. Problem area……………………… ________________________________

PATIENT CONSENT FORM

Please read the information on this form carefully before you sign. Please ask us if you need help to understand any part this form or if you want anything explained further.

Patients under 18 years of age

I, ... being the parent or legal guardian of
Print given name (s) and family

.... hereby consent to this person receiving
Patient given name (s) and family name

examination, x-rays, and treatment in this clinic.

Signature.. Date..........................

Chiropractors using manual therapy treatments for patients with neck problem are required to explain that there have been rare cases of injury to the arteries of the neck following treatment of the cervical spine. This occurrence has been known to cause stroke, sometimes with serious neurological, (nervous system), changes. All such accidents however, have involved rotation and/or extension of the neck. Neither of these movements are utilised in this technique practiced here, known as GONSTEAD. This safe practice method almost negates any chance of injury.

If you have any questions about this, do no hesitate to speak to either Doctors on duty.

I have read, or have had read to me and explained to my satisfaction, the above statements and I understand what they say. I accept the risk mentioned, and hereby consent to it for myself or for the above minor under my care.

SIGNED:..PRINT NAME:..Date:

ADDRESS:..

WITNESSED BY:..PRINT NAME:...Date:

I accept financial responsibility for my treatment in this clinic, or the treatment of the above minor under my care, and agree to pay the fees which have been explained to me at the time this service is rendered.

I understand that no accounts are held by this centre and my payment at the time of service will be by:

CASH ☐ EFT/CREDIT CARD ☐ CHEQUE ☐

SIGNED:..