RE-EXAM DETAILS

WELCOME TO CHIRO CONNECT AND THANK YOU FOR CHOOSING US

Please update the following details for our records

○ MR ○ MRS ○ MS ○ DR FULL NAME

DATE OF BIRTH AGE SEX MALE / FEMALE

ADDRESS

POSTCODE

CONTACT TELEPHONE NUMBERS (HOME) (WORK) (MOBILE)

EMAIL ADDRESS *

OCCUPATION IF RETIRED, PREVIOUS OCCUPATION

EMERGENCY CONTACT DETAILS (NAME AND PHONE)

IS YOUR COMPLAINT DUE TO AN INJURY THAT MAY BE CLAIMED ON ACC? ○ YES ○ NO IF YES, DATE OF INJURY

DO YOU HAVE A CURRENT CLAIM? ○ YES ○ NO IF YES, CURRENT CLAIM NUMBER:

IS YOUR CHIROPRACTIC CARE COVERED BY PRIVATE HEALTH INSURANCE? ○ YES ○ NO NAME OF FUND

ARE YOU ON AN AGED OR DISABILITY PENSION? ○ YES ○ NO (PLEASE PRESENT YOUR PENSION CARD)

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? ○ YES ○ NO IF YES, CHOOSE AN OPTION ○ SMS ○ EMAIL

MISSED APPOINTMENT POLICY

I, _____ understand that Payment is required at the time of consultation as Chiro Connect does not run accounts. We know your time is precious, as is the time of all our clients and Practitioners. We understand life doesn't always go to plan, however giving notice of appointment rescheduling or cancellation the day before your appointment is greatly appreciated, and allows that time to be used by other clients. If consideration of notice is not given, a missed appointment fee may be charged.

Client Signature_____ Date:_____
Parent or guardian to sign if client under age 16

PRIVACY AGREEMENT

I understand that all information obtained through my consultations is confidential. From time to time however, I understand that my health and care information may need to be shared with other practitioners to ensure I am getting the best and most appropriate health care possible. I understand that I can withdraw this consent at any time.

Client Signature _____ Date:_____
Parent or Guardian to sign if client under age 16

CHIROPRACTIC RE-EXAM

Chiro Connect
HEALTH · STRENGTH · VITALITY

ABOUT YOUR HEALTH HISTORY

Answering the following questions will help us to review important aspects of your health history and lifestyle. This will enable us to best determine how we may help you to achieve better levels of health and well being.

WHAT IS THE REASON FOR YOUR APPOINTMENT TODAY?

PROBLEM STARTED ON: TRIGGERED BY:

WHAT AGGRAVATES, BRINGS ON YOUR CONDITION, OR MAKES IT WORSE?

WHAT LESSENS, RELIEVES YOUR CONDITION, OR MAKES IT FEEL BETTER?

PAINS ARE: ○ SHARP ○ DULL ○ POUNDING ○ CONSTANT ○ INTERMITTENT ○ OTHER

IS THE PAIN REFERRING TO DIFFERENT AREAS OF YOUR BODY? ○ YES ○ NO IF YES, WHERE?

HAVE YOU HAD PREVIOUS EPISODES OF THIS PROBLEM? ○ YES ○ NO IF YES, HOW FREQUENTLY?

IS THIS PROBLEM GETTING WORSE OVER TIME? ○ YES ○ NO

IS THIS CONDITION INTERFERING WITH: ○ SLEEP ○ WORK ○ ROUTINE ○ OTHER

DO YOU CURRENTLY TAKE ANY MEDICATIONS/ DRUGS? PLEASE LIST...

HAVE YOU HAD ANY OPERATIONS SINCE WE LAST SAW YOU? PLEASE LIST...

HAVE YOU HAD ANY ACCIDENTS, INJURIES, FRACTURES, FALLS SINCE WE LAST SAW YOU? PLEASE LIST...

HOW MANY HOURS WOULD YOU SPEND SITTING PER DAY?

HOW MANY HOURS OF SCREEN TIME DO YOU HAVE PER DAY?

DO YOU HAVE ANY OTHER CONCERNS REGARDING YOUR HEALTH?

DO YOU SMOKE? ○ YES ○ NO ○ PREVIOUSLY HOW MANY GLASSES OF WATER DO YOU DRINK EACH DAY?

HOW WOULD YOU RATE YOUR HEALTH?	0 1 2 3 4 5 6 7 8 9 10	0 - POOR / 10- EXCELLENT
HOW WOULD YOU CURRENTLY RATE YOUR EXERCISE LEVELS?	0 1 2 3 4 5 6 7 8 9 10	0 - POOR / 10- EXCELLENT
HOW WOULD YOU CURRENTLY RATE SLEEP QUALITY?	0 1 2 3 4 5 6 7 8 9 10	0 - POOR / 10- EXCELLENT
HOW WOULD YOU CURRENTLY RATE STRESS LEVELS?	0 1 2 3 4 5 6 7 8 9 10	0 - LOW / 10- HIGH
HOW WOULD YOU CURRENTLY RATE DIET?	0 1 2 3 4 5 6 7 8 9 10	0 - POOR / 10- EXCELLENT

FOODS YOU AVOID/LIMIT?

DO YOU, OR HAVE YOU EVER HAD, PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE TICK IF THE ANSWER IS YES.

- ○ ALLERGIES OR ASTHMA
- ○ ANXIETY/DEPRESSION
- ○ ARM OR LEG PAINS
- ○ ARTHRITIS
- ○ BALANCE
- ○ BLOOD DISORDERS
- ○ BOWEL/INTESTINES
- ○ BRUISING EASILY
- ○ CHEST PAINS
- ○ CIRCULATION
- ○ COUGHING/ DIFFICULTY BREATHING
- ○ DIARRHOEA OR CONSTIPATION
- ○ DIZZINESS/BLACKOUTS
- ○ EARS/HEARING
- ○ EATING DISORDERS
- ○ EPILEPSY OR TREMORS
- ○ FEVERS/SWEATS/CHILLS
- ○ GALL BLADDER/LIVER
- ○ HAY FEVER/SINUSES
- ○ HEADACHES/MIGRAINES
- ○ HEART DISEASE
- ○ HIGH/ LOW BLOOD PRESSURE
- ○ LACK OF ENERGY/ FATIGUE
- ○ LOW IMMUNE SYSTEM
- ○ LUNGS
- ○ NAUSEA OR VOMITING
- ○ NUMBNESS
- ○ OSTEOPOROSIS
- ○ PAIN AT NIGHT
- ○ PANCREAS/SUGAR LEVELS
- ○ PINS & NEEDLES/ TINGLING
- ○ PSYCHIATRIC PROBLEMS
- ○ SPORTS INJURIES
- ○ STROKE/ PARALYSIS
- ○ SWELLING
- ○ TONSILLITIS
- ○ ULCERS
- ○ URINARY PROBLEMS
- ○ UNEXPLAINED WEIGHT LOSS
- ○ VISUAL PROBLEMS
- ○ WHIPLASH

FOR MEN ONLY

- ○ FERTILITY
- ○ GENITALS
- ○ PROSTATE

FOR WOMEN ONLY

- ○ BREASTS
- ○ FERTILITY
- ○ MENOPAUSE
- ○ OVARIES/UTERUS
- ○ MENSTRUAL PROBLEMS
- ○ ARE YOU CURRENTLY PREGNANT?
- ○ HOW MANY PREGNANCIES HAVE YOU HAD?

PLEASE PROVIDE FURTHER INFORMATION:

WHAT WOULD YOU LIKE TO ACHIEVE WITH YOUR CHIROPRACTIC CARE?

CONSENT TO CHIROPRACTIC CARE

PLEASE READ AND SIGN BELOW IN THE PRESENCE OF YOUR CHIROPRACTOR

Chiro Connect provides functional, holistic, integrative healthcare that is safe and effective for your whole family - even kids and babies. Following our comprehensive history assessment, we will undertake a thorough full-body examination before consideration of treatment. As such, informed consent regarding chiropractic care is required. Please read the following.

1. Adverse events from chiropractic care tend to be minor - such as slight muscle or joint stiffness/soreness, or dizziness/lightheadedness. Serious adverse events - such as fracture, disc injury or stroke are so rare that they are difficult to assess accurately. Serious events may occur between 1 in 20,000 and 1 in several million. In fact, there is no more risk of stroke from seeing your chiropractor OR your medical practitioner for headache or neck-related pain.

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

_____

_____

3. I have had the opportunity to discuss the proposed care with the below-named 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 any chiropractor working for Chiro Connect. I understand that I can withdraw consent at any time.

NAME OF CHIROPRACTOR _____ CHIROPRACTORS SIGNATURE _____

CLIENT'S SIGNATURE _____

(PARENT OR GUARDIAN TO ALSO SIGN IF CLIENT IS UNDER 16)

CLIENT'S NAME (PRINTED) _____ DATE _____