FamilyHealthProfessionals HELENSVALE

Southport Chiropractic CLINIC

New Patient History

File # _____

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

Title: Dr / Mr / Mrs / Miss /Ms GIVEN NAMES: _____ SURNAME:_____

OCCUPATION: _____ Date of birth: _____/_____/_____

ADDRESS: _____

SUBURB: _____ POST CODE: _____

PHONE:_____ Email:_____

Spouse Name:_____ Children:_____

Emergency Contact Name: _____ Relationship to You:_____ Contact Number:_____

Medical Doctors Name: _____ Contact Number: _____

How did you hear about us? Yellow Pages_____ Google_____ Signage _____ Staff_____

Clinic Patient (please provide their name so we can thank them) _____ Other _____

Reason for this visit (what is your chief complaint): _____

When and how did your symptoms start: _____

What makes your symptoms better: _____

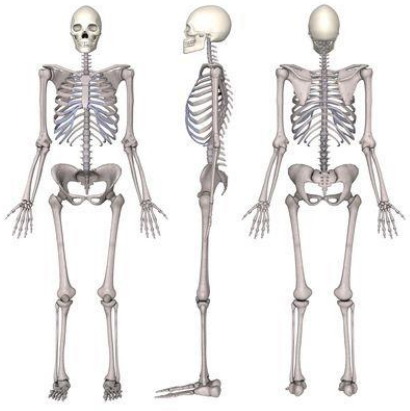
What makes your symptom worse: _____

Details of past treatment: _____

Secondary/Other Complaints: _____

_____

****PLEASE INDICATE BY CIRCLING AREAS OF CONCERN OR COMPLAINT ON THE DIAGRAM BELOW****



Are you on any medication? (if yes please note below)	Y N
Have you had a motor vehicle accident or serious injury?	Y N
Have you been admitted to hospital in the past 12 months?	Y N
Do you have any xrays, CT scans, MRI, Ultrasound?	Y N
Do you have any ongoing health problems?	Y N
Have you had any unexplained weight loss?	Y N
Have you had any abnormal bleeding from any body part?	Y N
Have you had any recent changes in a mole or freckle?	Y N
Do you have any unusual lumps or swellings?	Y N

If you answered yes to any of the above please supply details here: _____

_____

Is this a Work Cover* or Motor Vehicle** accident claim? (Please circle) Y / N

If Yes, When was the date of the accident? _____ What is your our approved claim number: _____

SYSTEMS REVIEW HISTORY

Please circle either Yes or No to the following questions about your general health.
This information will give us a better understanding about your body's overall function.

Headaches	Y N	Neck pain	Y N
Dizziness	Y N	Neck stiffness	Y N
Blurred vision	Y N	Mid back pain	Y N
Ring / buzz in ears	Y N	Chest pain	Y N
Difficulty swallowing	Y N	Palpitations	Y N
Loss of consciousness	Y N	High blood pressure	Y N
Numbness in any body part	Y N	Low blood pressure	Y N
Weakness in any body part	Y N	Heart trouble	Y N
Stroke	Y N	Difficulty breathing	Y N
Depression	Y N	Low back pain	Y N
Nervousness	Y N	Stomach trouble	Y N
Sleeping problems	Y N	Indigestion	Y N
Energy loss	Y N	Liver problems	Y N
Morning tiredness	Y N	Colon problems	Y N
Fainting feeling	Y N	Diabetes	Y N
Sinus problems	Y N	Kidney / bladder problems	Y N
Allergies	Y N	Poor circulation	Y N
Female problems	Y N	Upper limb problems	Y N
Male problems	Y N	Lower limb problems	Y N

Other: _____

_____

Relevant Family History: _____

_____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

We would like to include you on our email list so you receive our health updates and special offers, please check this box ☐ if you DO NOT wish to receive these emails.

I believe the information above is correct to the best of my knowledge. (Please sign below)

Cancellations: We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee may be charged.

Patient Name: _____Signature: _____Date: ___ /___ / 20___

** Work cover claims will need to be assessed for eligibility thru work cover online, until that time the patient is responsible for full payment of all treatment. ** For all other 3rd party claims we will provide you with an itemised receipt once you have paid in full, we will not process claims on your behalf.*

Consent To Chiropractic Care

When performed by a qualified Chiropractor, spinal manipulation is effective and safe method of treatment for many conditions. There are, however risks associated with any treatment and we are required to inform you of these, even though there has never been a serious injury in our clinic. Please read the following carefully, and note down any questions you may have.

I hereby request and consent to the performance of Chiropractic treatment on me by Dr Luke Hennessy Bsc. M Chiro and/or any other Chiropractor practicing in this clinic, authorised by Dr Hennessy.

I understand, and I am informed that, as in the practice of medicine, in the practice of Chiropractic there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke-like episodes.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the treatment, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I am aware that this clinic works on an open door policy and that I can request the presence of a Chiropractic Assistant at any stage of my care.

I understand that neither I, nor any persons accompanying me, are permitted to use recording devices whilst in the practice unless prior approval has been granted by the Chiropractor.

I have read the above, and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover all treatment for which I present. I understand that I can withdraw my consent at any time.

Patient Name: _____ Patient Signature: _____ Date: ____/____/20___

I am aware that my initial consultation is free, with no obligation to progress to a comprehensive examination and or treatment. However, I understand that I am responsible for payment of fees incurred on the day of service if I choose to proceed to the examination. I also understand that any “third party” claims through Medicare (EPC), Department of Veterans’ Affairs and or Workcover will be my responsibility if the “third party” rejects the claim.

Patient Name: _____ Patient Signature: _____ Date: ____/____/20___