CONFIDENTIAL INFORMATION FORM

FULL NAME: ____

ADDRESS: ____

PHONE: **Home:** ________________ **Work:** ________________ **Mobile:** ________________

EMAIL: ____

DATE OF BIRTH: ________________ **OCCUPATION:** ________________**HOURS / WEEK?** ________

PRIVATE HEALTH INSURANCE? Y/N ________________________**CONCESSION CARD HOLDER? Y/N**

Who referred you, or where did you hear about us? Please circle: Friend referral – who? ________________

Walking past / Website / Mail outs / Newspaper / Other - ______________________________

Name of GP : ______________________________**Permission to contact for labs, x-rays? Yes / No**

Reason for last visit? ____

Do you wish to receive Palmer Family Chiropractic health e-newsletters? Yes / No

Can the clinic use your email address to contact you concerning your care? *(Including appointment reminders?)* **Yes / No Email Address:** ______________________________

. . . . . / / . . . . .

Give a brief detailed description of the problem you are currently experiencing: ________________

____

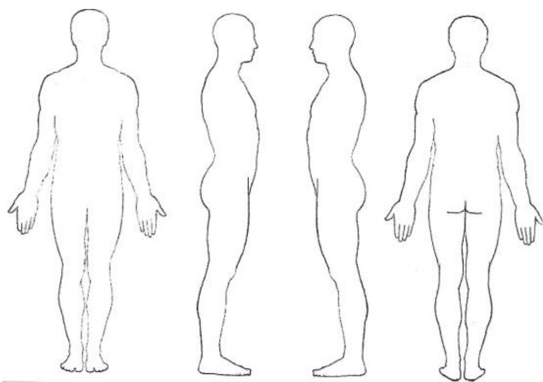
____

How long have you had this condition? ________________________ **Is it getting worse? Yes / No**

Does it bother you at: Work / Sleep / Other: ______________________________

What seemed to be the initial cause? ______________________________

Please mark your area(s) of pain on the figure below:



Do any of these stressors apply to you?

Physical	**Emotional**	**Chemical**
☐ Prolonged sitting	☐ Money	☐ Alcohol
☐ Poor posture	☐ Family	☐ Caffeine
☐ Heavy lifting	☐ Illness	☐ Tobacco
☐ Sedentary	☐ Work	☐ Junk food
☐ High heels	☐ Relationships	☐ Lack of water
☐ Lack of sleep	☐ Anxiety	☐ Medications
☐ Gadgets / computers	☐ Change of situation	☐ Processed foods

Mothers Side

☐ Cancer	☐ Kidney Disease
☐ Hypertension	☐ Dementia
☐ Stroke	☐ Diabetes
☐ Arthritis/Osteoporosis	☐ Other: ________________

Father's side

☐ Cancer	☐ Kidney Disease
☐ Hypertension	☐ Dementia
☐ Stroke	☐ Diabetes
☐ Arthritis/Osteoporosis	☐ Other: ________________

How is most of your day spent? Standing / Sitting / Other: ______________________________

What position do you sleep in? Side / Back / Stomach

BP Reading (Staff will take): ____/____ P ____

INFORMED CONSENT TO CHIROPRACTIC CARE

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

☐ I here request and consent to the performance of Chiropractic treatment on me any authorised Chiropractor working at Integrated Wellbeing Centre.

☐ I have had the opportunity to discuss with a Chiropractor representing Integrated Wellbeing Centre the nature and purpose of Chiropractic Treatment

☐ I understand that results are not guaranteed.

☐ 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 judgement 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 accept all responsibility for all fees incurred at this centre, and understand there will be a $20 fee incurred on all non-attended appointments.

☐ If my claim is a Worker's Compensation claim, I agree to pay the total fee incurred as this centre doesn't take any responsibility in sending statements to Workcover.

☐ I intend this consent form to cover the course of treatment for my present condition, and for any other condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time. This consent form will make null and void any previous consent forms signed by me.

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

____
Patient's Full Name

____
Representing Chiropractor

____
Patient's Signature

____
Date:

Office Use Only:
Computer updated: ☐
File Updated: ☐
Date for Renewal: ________________
CA Initial/date