COASTLINE Chiropractic CENTRE

Helping you restore your body's balance and freedom

Adult Questionnaire

Date:_____

It is our pleasure to welcome you to our clinic. Please complete the following questionnaire. Your answers will help us to determine whether Chiropractic can help you. Please note this is a postural and spinal examination only. If treatment is required you will be advised of this. Thank You

Your Details

Name: Mr/Mrs/Mstr/Miss/Ms/Dr _____
First *MI* *Surname*

Gender: ☐ Male ☐ Female Date of birth: ___/___/___

Address: _____
Street # *Street Name* *Suburb* *PCode*

Postal Address: _____
As Above *Street #* *Street Name* *Suburb* *PCode*

Contact details:
Home PH: _____
Mobile PH: _____
Work PH: _____
E-mail: _____

Preferred method of contact number:
☐ home
☐ mobile
☐ work

Are you a member of a private health fund?
☐ No ☐ Yes - Fund Name:_____

Is your chiropractic care covered by Veteran Affairs or Medicare Enhanced Primary Care (EPC)?
☐ No ☐ Yes (Please present your referral form to us)

Occupation: _____

If retired or unemployed, your previous occupation: _____

Name(s) of other Family members (s) and age(s): _____

_____

_____

_____

_____

OFFICIAL USE:
Name.....
File Number.....

Referrals

We appreciate Referrals. How did you find out about our clinic?

☐ Friend, please specify: _____

☐ Family member

☐ Yellow Pages

☐ Other (please specify): _____

☐ Another Health Professional

☐ Our Signage

Patient Consent

I consent to undergoing an examination to determine the cause of the condition for which I have attended the clinic. The examination may entail photographic or video recordings for inclusion in my records. Further consent will be obtained for any treatment after the examination and an explanation of the findings.

Signed:_____ Dated_____

I accept financial responsibility for my consultations and treatment. Fees are due at the time of visit unless agreed in advance. Unauthorised late payments will attract fees and interest, details of which are available on request. Insurance policies are an agreement between the insurer and myself, and I am responsible for any fees I am unable to claim through a policy. I remain responsible for any fees that the Clinic is unable to recover through these schemes.

Twelve hours notice of cancellation of appointments is required or the full fee for the appointment will be due. The Clinic may waive any of the above on occasions. If the Clinic does so it reserves the right to enforce the agreement at a later date.

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 providers 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.

I understand that the practice supports the expansion of clinical knowledge and expertise. One of the ways it does this is by using clinical information for education, and scientific and case studies. All identifying information is removed from any data before it is used. I consent for my information to be used in this manner. I understand I may remove this consent at any stage without compromising my care in any way.

Patient/ Clients name:_____Dated:_____

Patient/ Client Signed:_____

PLEASE NOTE: This section will be completed in the centre.

OFFICIAL USE:

Name.....

File Number.....