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: _____

Please let us know the names and ages of your next of kin:_____

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Name.....

File Number.....

Referrals

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

☐ Friend, please specify: _____
☐ Family member
☐ Yellow Pages
☐ Google:
☐ Another Health Professional
☐ Our Signage

If known, what is the name of your referral contact?_____

Present State of Health

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms then please describe these as fully and informatively as you can by answering the following:

Major symptom/problem _____

When did the pain/problem start?_____ triggered by_____

Have you had previous episodes of this problem? ☐ No ☐ Yes: No. times:_____
How would you describe the pain? ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent
Is the pain referring to other areas of your body? ☐ No ☐ Yes: Where?_____
Is condition getting worse? ☐ No ☐ Yes
What brings on your condition or makes it worse?_____
What relieves your condition or makes it feel better?_____
Is this symptom/condition interfering with: ☐ Work ☐ Sleep ☐ Routine
☐ Other (please specify)_____

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Medications and Medical Health

Please list any medications you take, along with the dose and reason for taking them

_____

_____

_____

_____

Have you received chiropractic care before? ☐ Yes ☐ No

If yes, when did you last visit a chiropractor? _____

If yes, were you pleased with the service you had received? ☐ Yes ☐ No ☐ Not sure

Have you ever had spinal X-rays taken? ☐ Yes ☐ No

If yes, where did you have them taken? _____

_____

If yes, which spinal areas did you have X-ray taken of? ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

Have you seen other Doctors/Practitioners seen for this condition? ☐ No ☐ Yes

If yes, please indicate type of practitioner: ☐ GP ☐ Chiro ☐ Physio ☐ Other

Please list any home remedies employed: _____

DAILY ACTIVITIES

Do your daily activities involve:

☐ sitting	☐ walking	☐ heavy lifting	
☐ writing	☐ driving	☐ manual work	☐ repetitive tasks
☐ standing	☐ phone use	☐ desk work	☐ emotional stress

Do you play a musical instrument? ☐ No ☐ Yes

Do you read for prolonged periods? ☐ No ☐ Yes

Do you wear: ☐ dentures / a plate ☐ glasses or bifocals ☐ contact lenses

Please describe:

Sleeping posture ☐ side ☐ back ☐ stomach

Sports you play or used to play _____ ☐ currently play ☐ used to play

_____ ☐ currently play ☐ used to play

_____ ☐ currently play ☐ used to play

_____ ☐ currently play ☐ used to play

Are you trying to: ☐ Gain weight ☐ Lose weight ☐ Neither

Do you exercise? ☐ Daily to weekly ☐ Occasionally ☐ Rarely/Never

Do you smoke? ☐ No ☐ Yes:_____ how many cigarette packets per day

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

The following Documents covers essential information relating to your Informed Consent, Outcome of treatment, Waiver and Signed Consent. Please read then sign and date if you are satisfied. We welcome you to discuss with us if you have concerns.

Informed Consent

Chiropractic care is an established professional allied health service that is acknowledged to provide an effective and safer approach for many musculoskeletal conditions. As you begin Chiropractic Care, there is certain information that you must be informed.

Your therapy and treatment may include:

- Chiropractic adjustments involving manual therapy of the body including spine, pelvis and the skull
- Soft tissue therapy
- Postural and Rehabilitation Exercise.

Alternative Treatment options

There are numerous therapeutic options for Musculoskeletal conditions

These include: Massage, Physical Therapy, Acupuncture, Osteopathy and Medication.

Possible outcomes

Individual response to Chiropractic treatment will vary. There may be an improvement, no change or a worsening of symptoms. Scheduled apart of the care management are routine examinations to assess your change.

Potential Risks of Proposed Treatment

The rare risks associated with the proposed care includes (not limited to):

- muscle and joint soreness or strains,
- nausea and dizziness
- exacerbation and/or aggravation of the underlying condition.
- In very rare circumstances, some treatments of the neck may damage a blood vessel and possible Stroke or related symptoms (current statistics: between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999).
- Strain/injury to a Ligament or a Disc in the Neck (current statistics: less than 1 in 139,000) and the Low back (current statistics: 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.).
- For some patients a fracture of a bone is possible, although rare, especially with bone weakening diseases.

Waiver

I hereby acknowledge my consent to the performance of the proposed chiropractic care Darren J Gray or any other chiropractor working in this centre. I understand that I can withdraw consent at any time.

I will have the opportunity to discuss the proposed care with chiropractor. I also acknowledge that I will have had the chance to ask questions about the nature, extent and purpose of the recommended chiropractic care and I have been given sufficient time to make a decision providing consent for the care to proceed.

OFFICIAL USE:

Name.....

File Number.....

Patient Consent Form

I consent to undergo an examination to determine the cause of the condition for which I have attended the Clinic. The consultation 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:_____

(Parent or Guardian to sign)

I accept financial responsibility for my consultations and treatment. Fees are due at the time of consultation 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 costs I am unable to claim through a policy. I remain liable for any charges 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.

Under the new Privacy Act, all information relative to your case is held in total confidence. Howeve , your consent is necessary to allow us to exchange data 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 data to be used in this manner. I understand I may withdraw this consent at any stage without compromising my care in any way.

Signed: _____ Dated:_____

(Parent or Guardian to sign)

OFFICIAL USE:

Name.....

File Number.....