Confidential Patient Information

Given Name: …….. Surname: ……..……Date of Birth: ……

Address: …… Suburb:…… P/Code: ……

Tel: (H). ……. (W). …….. (M) ……

Email: …… Occupation: ……..…….

How did you find out about us (who referred you)? ……

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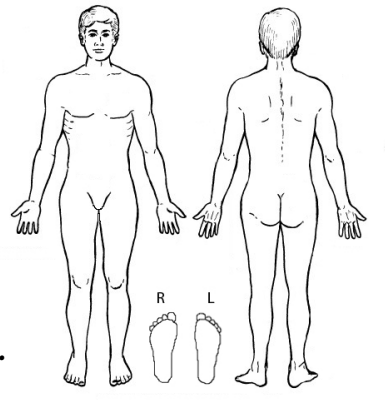
1) Reasons for attending this clinic

Wellness ☐ Specific problem ☐ (explain below)

……

……

……



If relevant, also indicate the location of symptoms on the adjacent diagram.

Please complete questions 2 to 9 if you are attending due to a specific health problem:

2) When was the problem first noticed? …… 3) Has it worsened (please circle)? **YES NO**

4) What makes it worse? ……. 5) What makes it better? ……

6) Have you had this problem before (please circle)? **YES NO** (7) If YES, when was the last time?…….

8) Previous assessments or tests: ……

9) Previous treatments (include dates where possible): ……

Please provide detailed responses to questions 10 to 17 below if applicable:

10) Please list any specific illnesses or health problems that family members or relatives have suffered from:

……

11) Please list any accidents or trauma that you have experienced in the past, and when:

……

12) Please list any current or recent medications, supplements/herbals or social drugs that you have used:

……

13) Please list any illnesses that you currently or previously experienced, and when:

……

14) Please list **any** surgeries or hospitalisations that you have required in the past:

……

16) Please list your usual sport, exercise and recreational activities:

……

17) Have you ever smoked, and how much? …… Describe your alcohol use: ……

Have you experienced any of the following in the past month or since the onset of your main presenting health problem (please tick)?

- Nausea or vomiting ☐
- Fever or rashes ☐
- Fatigue not resolved by sleep ☐
- Weight loss ☐
- Weight gain ☐
- Changes to hair, nails or skin ☐
- Difficulty breathing ☐
- Chest pain or discomfort ☐
- Fainting or loss of consciousness ☐
- Reduced urinary or bowel control ☐
- Pain or blood loss during urination or bowel movements ☐

Have you ever been diagnosed with any of the following health problems (please tick)?

- High blood pressure ☐
- Low blood pressure ☐
- High cholesterol or triglycerides ☐
- Stroke or aneurysms ☐
- Anaemia/Low iron levels ☐
- Thyroid problems ☐
- Cancer ☐
- If so, specify type:……
- Diabetes or abnormal blood sugar levels ☐
- Allergies or immune related conditions ☐
- Bone or joint disease ☐
- If so, specify type:……

Functional Limitations Rating Scale

To what extent does your health condition limit or affect you in the following activities?

Activity	Frequency						Severity		
	Never 0	Rarely 1	Sometimes 2	Often 3	Most of the Time 4	Always 5	Mild 1	Moderate 3	Severe 5
Standing									
Sitting									
Lying down									
Walking									
Food prepara-tion & eating									
Going to the toilet									
Showering, bathing and personal care									
Social activities									
Work or study activities									
Exercise or recreation activities									

Common Neurological Symptoms Screening Questionnaire – SF20

Please indicate if there have been any problems with the following items **over the past month**, or **since the onset of your main health problem**. Use the white boxes to rank the frequency of **EVERY** item, and the grey boxes to rank the severity of each item, unless 'Never' is selected.

Item	**Frequency**						**Severity**		
	Never 0	Rarely 1	Sometimes 2	Often 3	Most of the Time 4	Always 5	Mild 1	Moderate 3	Severe 5
Vision									
Balance									
Dizziness									
Hearing									
Tinnitus									
Headaches									
Numbness or tingling									
Weakness									
Tremors, tics or twitches									
Motor skills (e.g. coordination)									
Attention									
Reading or spelling									
Communication (e.g. speech or conversation)									
Memory									
Hyperactivity or impulsiveness									
Obsessions or compulsions									
Stress									
Depression									
Anxiety or panic									
Sleep problems									

Please read the following information carefully before signing:

Policies on Fees, Guarantees & Disclosed Information

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation. I will also discuss any consultation fees with a health practitioner or staff member at this clinic prior to the service being provided.

2) I appreciate that **positive results of any treatment** that I receive at McKenzie Chiropractic **is not guaranteed**.

3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

4) We take all precautions that are known by this clinic to assure that your confidential records are not available to those that do not need them. Before we release any aspect of your file to any party we require your written authority. Your signature on this form will be compared to verify any written application for your records. If we are in doubt we will contact you to confirm.

5) From time to time we may contact you with thank you letters, reminders, birthday cards and health information. By signing below, you give us permission to do so. You may "opt out" at any time.

Risks of Care & Consent for Care

6) Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications.** This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.

7) I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.

8) The alternatives to chiropractic treatment are: no treatment, medicine, physiotherapy or acupuncture.

9) I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Patient's Signature (if 16 or older): …… **Date**: ……

Parent's Signature (if patient is under 18): ……..……**Date**: ……

Please print name/s here: ……..……

***** Please bring any previous reports, scans or test results that may be relevant for your assessment.**

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