



**We are different -**

- All humans are designed to heal. Therefore **you** are designed to heal.
  - Illness and disease may be present without pain. Many people will feel better from care, but, pain relief is not our primary objective. Our goal is to help you express more life through optimal health.
- Your current condition, is the result of a *lifetime of events*. Stress interferes with the ability of your body to function.

**Please Note - If further examination is required from today's consultation, you will be referred out for x-rays and no treatment will be given. — We will not play guesswork with your health.**

**Why are you here today?**

\_\_\_\_\_

How long has this affected you? \_\_\_\_\_ Have you had similar problems before? Y/N

If you are experiencing pain, how would you describe it? Sharp Dull Constant Intermittent

What is it caused/aggravated by?: \_\_\_\_\_

Is it getting worse? Y/N What lessens your pain? \_\_\_\_\_

What previous treatment have you received? \_\_\_\_\_ Result: \_\_\_\_\_

Previous chiropractor name and location: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Existing patient (please name so we can say thank you): \_\_\_\_\_

Walked past Yellow pages Other (please specify): \_\_\_\_\_

We are a clinic that relies on referrals from our clients. Let them know how it is possible for them to reach their full potential through chiropractic care by sending them into our office!

<b>Name:</b>		<b>Today's date:</b>
<b>Address:</b>		<b>Suburb/Postcode:</b>
<b>Home phone:</b>	<b>Mobile:</b>	<b>Email address:</b>
<b>Date of Birth:</b>	<b>Height:</b>	<b>Weight:</b>
<b>Occupation:</b>	<b>Health fund:</b>	<b>Marital status:</b>
<b>Partner's name:</b>	<b>Names and ages of children:</b>	
<b>GP</b>	<b>GP Address and phone number:</b>	

## MEDICAL HISTORY

Have you had any:		If yes, please describe
Injuries	Y/N	
Motor vehicle accidents	Y/N	
Surgery ( <i>list all</i> )	Y/N	
Prominent scars	Y/N	
Medications	Y/N	

Do you/ have you suffered from: (please tick all that apply)	
Disturbed sleep	Pneumonia
Unexplained weight loss	Attention deficit disorder
Night sweats	Polio
Ulcers	Cancer
Anaemia	Epilepsy
Thyroid problems	Diabetes
Stroke	Multiple Sclerosis
Glandular fever	Infertility
Mumps	Arthritis
Measles	

Are you aware of any genetic disorders in your family?

**If you ticked any of the above, please explain further:**

### Have you ever:

Been knocked unconscious?	Used a cane or crutch?
Had a fractured/broken bone?	Been hospitalised?
Had a spine or nerve disorder?	

**If you circled any of the above, please explain further:**

Please tick any relevant issues relating to your body system function:	Please describe
<b>Gastrointestinal Issues</b> (IBS, Vomiting, Nausea etc)	
<b>Nervous system symptoms</b> (Pins and needles, Numbness, Spasms etc)	
Respiratory Issues (Asthma etc)	
Urinary issues	
Skin problems	
Ear nose or throat concerns	
Cardiovascular issues	
<b>Any other health issues not mentioned:</b>	

**How would you rate these areas of your health (please circle):**

	Low/poor	High/best	Please explain further
<b>Stress</b>	1 2 3 4 5 6 7 8 9 10		
<b>Nutrition</b>	1 2 3 4 5 6 7 8 9 10		
<b>Exercise and fitness</b>	1 2 3 4 5 6 7 8 9 10		

## LIFESTYLE

Do you wear orthotics in your shoes? Y / N

How many pillows do you use? \_\_\_\_\_

What is your sleeping position? Side Back Stomach

What type of mattress do you have? \_\_\_\_\_

How would you rate your current level of wellness (0 = poor, 10 = optimal) \_\_\_\_\_

## CONSENT TO CHIROPRACTIC CARE

At Knox Chiropractic & Wellness, we aim to provide the highest quality care. Part of this care may involve cervical (neck) adjustments. As with any health care procedure there is some risk, currently this is estimated between 1 in 1million to 1 in 5.85million for stroke or stroke like symptoms. Other rare risks can include disc injuries, rib fractures, sprains/strains or aggravation of pre-existing conditions. We take every precaution to ensure that this risk is minimised through thorough testing, examination and the use of gentle and specific techniques. If you have concerns, please let your chiropractor know. By signing this you acknowledge that you have been informed of the risks involved and understand that you have had an opportunity to ask questions, you understand that you entitled to withdraw consent at any time.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Our Office policies to help you get the best results in our clinic.*

- 1) Please arrive on time for your appointment. To get preferred times, please pre-schedule all appointments.
- 2) If you require a longer time with one of the Chiropractors please inform the staff.
- 3) If you have to re-schedule an appointment, please book within 24 hours to maintain consistency of care.
- 4) When called to a table, please lie face down. This allows the spine and surrounding muscles to relax before an adjustment.
- 5) A 3-5 minute walk and two glasses of water are required after an adjustment to maximise your response to an adjustment.
- 6) We will always contact you if you have missed an appointment or failed to book another one. This helps with your accountability to your health. If you do not want this, please inform the staff as soon as possible.
- 7) **As part of our communications with you, you will be added to our mailing list. Our emails are the most effective way to stay up to date with activities within our office. This may help you avoid missing vital updates about the clinic.**

TICK THIS BOX IF YOU CHOOSE NOT TO BE ADDED TO THE MAILING LIST

**By signing below, you agree to the policies listed. You also authorise 360wellness to contact relevant health providers to obtain details pertaining to your health.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_