Flex
Health Professionals

Chiropractic Intake Form

Contact Information

Title (Please circle one): Dr Mr Mrs Ms Miss Master

Surname: _____ **First Name:** _____

Date of Birth: _____ **Preferred Name** (Optional): _____

Address: _____ **Suburb:** _____ **Postcode:** _____

Home Phone: _____ **Mobile:** _____ **Work Phone:** _____

Email: _____

Emergency Contact

Name: _____ **Relation:** _____ **Contact #:** _____

Do you have Private Health Cover? ☐ No ☐ Yes (Please specify): _____

Occupation: _____

Have you seen a chiropractor before? ☐ No ☐ Yes (How long ago?) _____

Do you have a regular GP/GP Practice? ☐ No ☐ Yes (Dr Name): _____

How did you hear about this clinic? _____

Please Read Before Continuing

The taking of a history and conducting a physical examination are not considered treatment, but are part of the information gathering process required to determine if chiropractic care may help me. I have read this statement and give my consent for the information gathering process. I also give consent for details regarding my clinical history and treatment to be shared with appropriate 3rd parties such as my GP and other health professionals if required.

Signature: _____ **Date:** _____

Primary Condition & Symptoms ... How can we Help You?

1. **What is the main reason for your consultation today?** _____

2. **What do you think caused the problem?**

   _____

   _____

3. **Is it a work-related injury?** _____

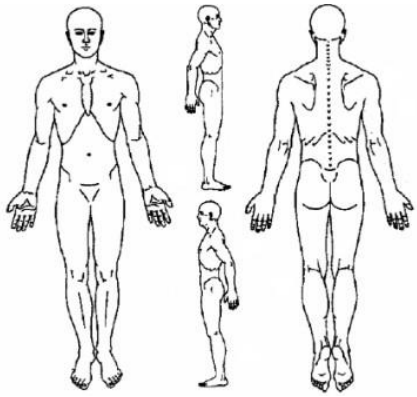
4. **How long have you had this problem?** _____

   And Is it... ☐ Getting Better ☐ Staying the Same ☐ Getting Worse ☐ Comes & Goes

5. **Rate the severity:** 0—1—2—3—4—5—6—7—8—9—10

6. **When is the problem worst?** ☐ Morning ☐ Afternoon ☐ Evening ☐ At night in bed ☐ On-and-off ☐ Constant ☐ During activity

Draw where you feel the problem



Personal Health History

7. Do you have any other health conditions? (eg. Cancer, Diabetes, High Blood Pressure)

☐ No ☐ Yes (Describe) _____

_____

8. Do you take any medications? If yes, please list: (eg. blood thinners, pain killers, anti-inflammatories)

_____

_____

9. Is there family history of ... ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Cancer
☐ Dementia ☐ Stroke ☐ Other _____

10.

Have you ever…?	**YES**	**NO**
Been diagnosed with a connective tissue disorder, rheumatoid arthritis, Ankylosing Spondylitis, Psoariatic Arthritis or other inflammatory arthritis?		
Been diagnosed with cancer or leukaemia or under an Oncologist currently?		
Had a significant physical trauma such as a fall or car accident (or motor bike accident)?		
Had surgery of your spine or joints (pin/plate, screws, fusion, stabilization, joint replacement)?		
Or any previous surgery of any type?		
History of fracture, dislocation or ligament rupture?		
Previous diagnosis of an aneurysm, TIA, stroke or stroke-like symptoms?		
Had a diagnosis of a cardiac problem such as high blood pressure, heart attack, angina, abnormal rhythyms?		

General Health Review

Please tick if you have an ongoing history of any of the following symptoms:

General
☐ Always cold
☐ Always hot
☐ Anxiety/Depression
☐ Balance/Falls
☐ Fainting
☐ Fatigue
☐ Sleep problems
☐ Memory loss
☐ Pain waking at night
☐ Seizures
☐ Tremors
☐ Unexplained sweats
☐ Unexplained weight loss

Muscle & Joint Pain
☐ Arthritis
☐ Bursitis
☐ Headaches/Migraines
☐ Low back pain
☐ Neck pain
☐ Pain between shoulders
☐ Pins & needles in legs/arms
☐ Sciatica
☐ Scoliosis
☐ Joint swelling

Skin
☐ Wounds
☐ Bruise easily
☐ Dryness/Itching
☐ Excema

Cardiovascular
☐ Anaemia
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest pain (squeezing)
☐ Poor circulation
☐ Rapid Heart Beat
☐ Swelling in Ankles

Respiratory
☐ Asthma
☐ Chest Infection
☐ Chronic Cough
☐ Spitting blood or phlegm
☐ Wheezing
☐ Short of Breath

Although these symptoms may not be related to your condition, they will help us to identify other health issues that might affect your treatment.

Face & Head
☐ Hearing Problems
☐ Vision Problems
☐ Tinnitus
☐ Thyroid Disease
☐ Facial Pain
☐ Facial Drooping
☐ Jaw Problems

Gastrointestinal
☐ Stomach Pain/Reflux
☐ Appetite Change
☐ Bloating
☐ Blood in Stools
☐ Indigestion
☐ Irritable Bowel
☐ Gallbladder Problems
☐ Liver Problems
☐ Nausea/Vomiting

Genitourinary
☐ Blood in Urine
☐ Frequent Urination
☐ Excessive Thirst
☐ Incontinence
☐ Kidney Stones
☐ Painful Urination

Please hand this to reception when completed

Flex Health Professionals
90 Allnutt St
Mandurah WA 6210

P: (08) 9581 3331
F: (08) 6270 4447
E: admin@flexhp.com.au

Your Privacy: Our Policy

The provision of quality health care requires a practitioner-patient relationship of trust and confidentiality. Consistent with our commitment to quality care, Flex Health Professionals has developed a policy to protect patient privacy in compliance with current legislation.

Collection
This means we will collect information that is necessary to properly treat you. Such necessary information may include;

- Full medical history, family medical history, contact details
- Ethnicity, genetic information
- Medicare/private health fund details and billing/account details

The information will normally be collected directly from you. There may be an occasion when we will need to obtain information from other sources;

- Other medical practitioners, e.g GP's and specialists
- Other health care providers such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses, hospital and day surgery units.

Both our practice staff and health practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes for the management of our practice
- Referral to another medical practitioner or health care provider
- Referral for further tests e.g x-rays
- Referral to a hospital for treatment options
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations of notification to our medical defence organizations or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

Flex Health Professionals
90 Allnutt St
Mandurah WA 6210

P: (08) 9581 3331
F: (08) 6270 4447
E: admin@flexhp.com.au

Access

You are entitled to access your own health record at any time convenient to both yourself and the practice. Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access or if your request is frivolous
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
- In the interest of national security

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded, you are entitled to correct the information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

Consent

I provide my consent for the staff and practitioners at Flex Health Professionals to collect, use and disclose my personal information as outlined above.

I understand that I am entitled to access my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Patient Name: _____

Signed:_____

Date: _____