Level 6, 10 Bridge St, Sydney NSW 2000

(02) 9252 2825

www.quayhealth.com.au

WELCOME to Quay Health. For many of you this will be your first encounter with the Chiropractic profession. Congratulations on taking your first step in achieving better health.

About You

Name: Date of Birth: Age:

Preferred Name: Email:

Address: Postcode:

Phone (H): Mobile: (W):

Sex: M ☐ F ☐ Relationship status: Single ☐ Defacto ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation: Employer: Healthfund:

Emergency Contact's name: Phone:

Partner's name: Names/Ages of Children:

How did you hear about us?

Are you here for: A general check-up? ☐ A specific health concern? ☐ (if so, please continue below)

What is your main concern?

How long have you had it? D / W / M / Y How did it start? Unsure? ☐

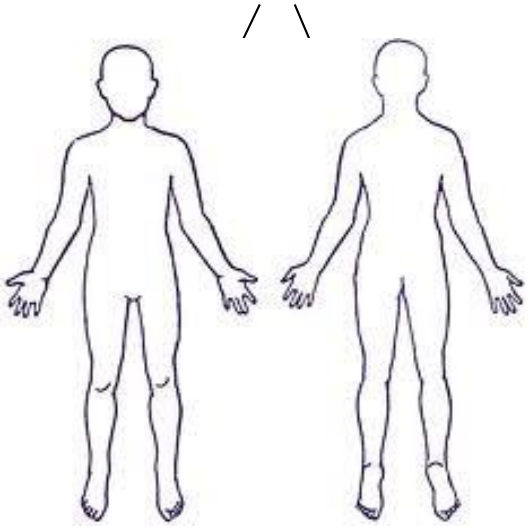
Have you had it before? No ☐ Yes ☐ If yes, how often and since when?

Have you seen anyone else for this problem? No ☐ Yes ☐ If so, Who?

Results? Excellent ☐ Good ☐ Satisfactory ☐ No Improvement ☐ Worse ☐

Have you had any spinal x-rays taken in the last 12 months? No ☐ Yes ☐

Please mark all areas of pain, stiffness or abnormal sensation in your body.



What is your pain/discomfort right now?

|_____|

No pain Severe pain

What is your typical or average pain?

|_____|

No pain Severe pain

Are you taking *any* medication? (What for? How much? How long?) _____

Are you taking *any* supplements? (What for? How much? How long?) _____

List *any* major illnesses or *any* surgeries and years: _____

_____

List traumas (car/home/sports/work injuries etc.) and years: _____

Mark past (P) or current (C) if you have ever had:

P	C		P	C	
☐	☐	Poor posture	☐	☐	Asthma/breathing issues
☐	☐	Headaches/migraines	☐	☐	Diabetes
☐	☐	Dizziness/loss of balance	☐	☐	Neck stiffness
☐	☐	Arthritis	☐	☐	Fatigue/irritability
☐	☐	Rheumatoid Arthritis	☐	☐	Prolonged steroid use
☐	☐	Stroke	☐	☐	Sudden/unexplained/recent weight loss
☐	☐	Heart Disease	☐	☐	Sleeping problems
☐	☐	Cancer	☐	☐	Aneurysm
☐	☐	General feeling of unwell	☐	☐	Fever
☐	☐	Sudden explosive/new type headache	☐	☐	Loss of bladder or bowel control

FEMALES ONLY: Is there any possibility that you may be pregnant at this time? No ☐ Yes ☐

FAMILY HISTORY - please indicate if there is a family history of any of the following conditions:

Cancer ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Diabetes ☐

Aneurysm ☐ Stroke ☐ Heart Disease ☐

Informed Consent To Treatment

1. I appreciate that **positive results of any treatment** that I receive at Quay Health **is not guaranteed**.
2. 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.
3. We will be reminding you of appointments via an external SMS service. As well as to keep you informed with the latest information via a monthly newsletter and via SMS periodically. All of which can be unsubscribed to or opted out of at any time.

Risks of Care & Consent for Care

4. 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.
5. I understand the risks mentioned above. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.
6. I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at any time.

I have read the above explanation of chiropractic care. I have also had the opportunity to ask questions and have them answered. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed Name:_____**Signature:**_____**Date:**_____

**If patient is a minor:*

Parent or Guardian Name:_____**Signature:**_____