Mangawhai Vitality Centre

1 Molesworth Drive, Mangawhai 0505 Ph. 09 431 5282

CONFIDENTIAL CLIENT INFORMATION

Title _____ **Date** _____

First Name _____ **Surname** _____

Date of Birth DD MM YYYY **Gender** MALE FEMALE

Mailing Address STREET ADDRESS 1 **Phone Numbers** HOME

STREET ADDRESS 2 WORK

CITY + POSTAL CODE MOBILE

E-mail Address _____ **Would you like to receive automated appointment reminders?** TEXT EMAIL

Occupation _____

Hobbies _____

Have you previously received Chiropractic care? _____

If so, who was your Chiropractor and why did you stop care? _____

How did you hear about Mangawhai Chiropractic?
(we love to thank our referring clients) _____

CURRENT HEALTH

Rate your current health status: TERRIBLE 1 2 3 4 5 6 7 8 9 10 FANTASTIC

Do you experience any of the following? (Circle all that apply)

Dizziness Fatigue Difficulty sleeping Allergies High blood pressure Loss of libido Difficulty breathing

Nausea Weakness Poor concentration Vertigo Abdominal pain Muscle cramping Sinus trouble

Menstrual problems Indigestion Poor circulation Depression Anxiety Stress Headaches Migraines

Night sweats Changes in bowel/bladder function Unexplained weight loss/gain Swelling Abnormal lumps

Other: _____

Rate your current health goals on a scale of 1 = most important to 4 = least important

Improved health/quality of life ____
Increased performance ____
Rehabiliation ____
Pain relief ____
Other _____ ____

HEALTH HISTORY

Have you been treated for any health conditions in the last year? Y N (If yes, please explain)

Have you ever been diagnosed with any chronic illnesses or conditions? Y N (If yes, please explain what and when)

Have you ever been hospitalised, had any surgeries or major accidents? Y N (If yes, please explain what and when)

How often do you get sick (cold, flu, sinus infection, etc)?

Have you had any x-rays or other imaging within the past 6 months? Y N (If yes, please explain)

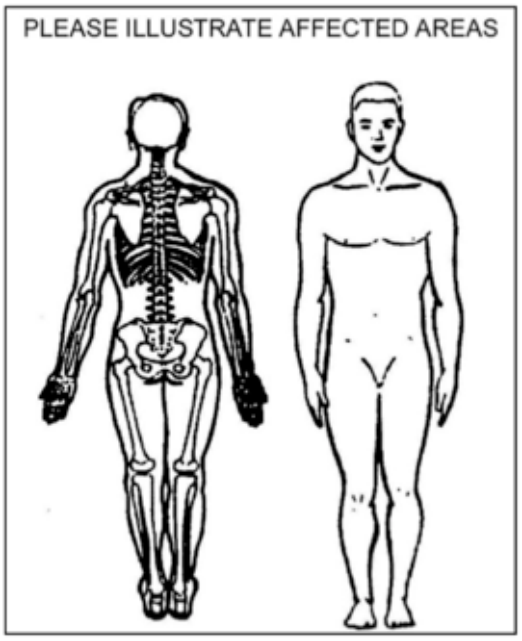
Are you taking any prescribed medications? Y N (If yes, please explain what and what for)

Are you taking any supplements? Y N (If yes, please explain what and how often)

TODAY'S VISIT

What has brought you to our practice today? _____

Please mark your areas of concern on the diagram



Primary area of concern: _____

Level of Discomfort (0 =none, 10 =severe): _____

Quality (sharp, dull, stabbing, achy, etc) _____

Recent onset date? _____

Has this ever happened before? _____

Original onset date? _____

Is there any family history of this? _____

Does anything make it worse? _____

Does anything make it better? _____

Have you received previous care for this? Y / N

If so, where and when? _____

Is the reason for today's visit due to a recent injury or accident? Y / N

Date of Injury _____

Do you have an existing ACC claim associated with this injury? Y / N

HEALTH HABITS

How many hours per day do you ***sit?*** _____

How many hours per day do you ***stand?*** _____

How long are you ***in front of a screen*** daily? _____

How much water do you drink per day? _____

Do you smoke cigarettes? Y / N (If yes, please explain how often) _____

Do you drink alcohol? Y / N (If yes, please explain how often) _____

Do you drink caffeine? Y / N (If yes, what and how often) _____

Do you exercise regularly? Y / N Please describe your exercise programme/sporting activities: _____

_____

INFORMED CONSENT

Chiropractic care, like all forms of health care, while offering considerable benefit, may be associated with some adverse effects. Adverse effects are rare and we endeavour to take all precautions necessary to avoid any complications. Some of the complications reported include sprain/strain injuries, irritation of a disc condition, and fracture. Vertebral artery injury and stroke is extremely rare and has been reported at an incidence of approximately 1 in 5 to 20 million cases.

Prior to receiving chiropractic care at Mangawhai Chiropractic, a health history and physical examination will be completed to assess your overall health, and in particular, the health of your spine. These procedures will be explained to you and will assist us in providing you with the highest quality of care and to determine if there are any indications to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you prior to initiating care.

I understand and accept that there are risks associated with chiropractic care and consent to the chiropractor performing the examinations he or she deems necessary and to the chiropractic care, including adjustments to the spine and extremities (where appropriate) following my initial assessment.

_____

Client Name

_____ _____

Client Signature Date