ROSE FAMILY CHIROPRACTIC PTY LTD

Confidential Patient Information

Dr Robert J. Rose DC & Reg. Acupuncturist
Dr David J. Coppi, B.Chiro, Sc., M. Chiroprac.
Dr Rebecca A. Rose. B.Chiro, Sc., M. Chiroprac.
Dr Su Hwan Kim BHSc(Chiro),MClinChiro(RMIT)

Patient ID:

Surname _____ **(Dr / Mr / Mrs / Miss / Ms)**

Given Names _____

Home Address _____

Postal Address _____

Phone No's Mobile _____ **Work** _____ **Home** _____

Email Address _____

Date of Birth _____ **Height** _____ **Weight** _____

Occupation _____ **Employer** _____

Who referred you? **Dr** ☐ **Relative** ☐ **Friend** ☐ **Yellow Pages** ☐ **Other** ☐

Name of the person referring you. _____

Name of your local doctor _____ **Suburb** _____

Last visit _____ **Emergency Contact** _____

Who is responsible for fees? _____

Do you have private health cover? Yes/ No Name of fund _____

Is there any third party involvement in relation to your treatment? Yes / No

Worker's Compensation Yes / No Claim Number _____

Motor Accident Commission Yes / No Claim Number _____

Do you have a Health Concession Card Yes / No

Number _____ **Expiry Date** _____

Reason for seeking Chiropractic Care or Spinal Check Up _____

_____

_____

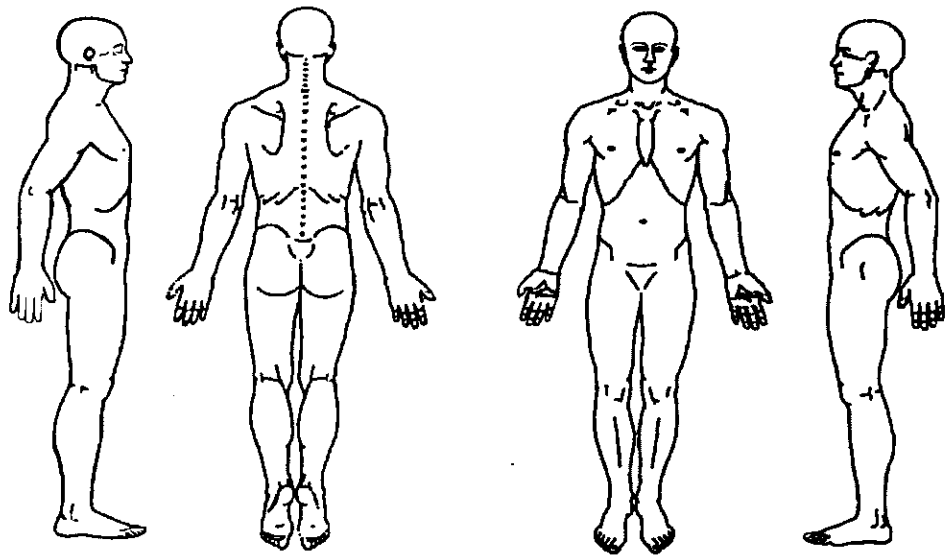
How long have you had the complaint? _____

Is your problem ☐ **Continuous or** ☐ **On / Off Is it worse?** ☐ **am** ☐ **pm**

Is your problem? ☐ **Getting worse** ☐ **Getting Better** ☐ **The Same**

What makes it better? _____

Please Mark Area(s) of Pain or Unusual Feeling



Any previous X-Rays?	☐ No	☐	Yes, Last x-rays?
Have you had a similar condition before?	☐ No	☐	Yes, When?
Have you had chiropractic care before?	☐ No	☐	Yes, Chiropractors name:

Previous Health History

If you have had any of the following, please state when and describe:-

				Please describe?
Have you ever been in hospital?	☐ No	☐	Yes	
Required surgery/operations?	☐ No	☐	Yes	
Had any serious illness and/or health problems?	☐ No	☐	Yes	
Are you taking any medication?	☐ No	☐	Yes	
Have you ever been involved in a car accident?	☐ No	☐	Yes	
Fractured/broken bones or bad falls?	☐ No	☐	Yes	
Mental or emotional disorders?	☐ No	☐	Yes	
Is there a family history of (cancer, diabetes, heart disease, high blood pressure, thyroid or kidney disease, tuberculosis), or (muscle, bone or nerve disease)?	☐ No	☐	Yes	
Do you exercise or play sport regularly?	☐ No	☐	Yes	
Do your joints ever swell?	☐ No	☐	Yes	
Do you experience any abnormal noises in your ears or head?	☐ No	☐	Yes	
Have you any lumps, cysts, or unusual swelling anywhere on your body?	☐ No	☐	Yes	
Are you subject to blackout, dizzy spells or faints?	☐ No	☐	Yes	
Has your weight changed more than 4kg in the last year?	☐ No	☐	Yes	Gain or loss?
Are you passing water more frequently?	☐ No	☐	Yes	
Do you have any pain or difficulty passing water?	☐ No	☐	Yes	
Have you experienced any change in bowel habits?	☐ No	☐	Yes	
Have you visited a subtropical or tropical country in the last year?	☐ No	☐	Yes	
Have you had a recent long distance trip (plane, car)?	☐ No	☐	Yes	
For **women**: Are you pregnant?	☐ No	☐	Yes	How many months?
				Number of Children

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Informed Consent to Chiropractic Care

Dr Robert J. Rose, DC
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Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you need to be aware that there are risks associated with all health care procedures.

It is legal requirement of any practitioner who performs spinal manipulation - including Chiropractors, Physiotherapists, and GP's - to inform you of the potential risks associated with these procedures.

One or more of the following risks may occur **occasionally** following manipulative therapy:

- Muscle and joint soreness and strains
- Dizziness
- Nausea
- Headaches
- Aggravation of your underlying condition.

The following are **extremely rare** risks that have been known to occur in very few cases following manipulative therapy:

- Fractures
- Disc injuries
- Vertebral artery injuries (strokes),

Acknowledgement:

I acknowledge that I do not expect the doctor of chiropractic to be able to anticipate all risks and complications associated with the proposed chiropractic care.

I acknowledge that I am aware of and understand the potential risks associated with that care.

I have had the opportunity to discuss with the doctor of chiropractic any concerns regarding my treatment, and have been given sufficient time to consider giving my consent for treatment to proceed.

I appreciate that results cannot be guaranteed.

I hereby give my consent to the performance of chiropractic treatment by the chiropractic practitioners named above and/or any other chiropractors working at this clinic. I intend for this consent to apply to all present and future treatments, but understand that I may withdraw consent at any time.

Patient's Signature _____ Print Name _____

Chiropractor's Signature _____ Date ____ / ____ / ____

Our Rescheduling and Cancellation Policy

The Secret is out our Chiropractors are fantastic!!

This means that our Chiropractors are always in demand. If you are unable to make an appointment we would appreciate 6 hours notice. We can then reschedule your appointment and call a client on our cancellation list that has been waiting to see us.

We understand life is hectic so our policy is as follows:

1st Missed appointment – **we understand**

2nd Missed appointment – **our cancellation policy will apply - $10**

3rd missed appointment **- our cancellation policy will apply $25**

4th missed appointment – **You will be required to pay the FULL AMOUNT for the missed appointment - $53**

If 6 hours notice is not given you may be charged a $10 cancellation fee

There will be no further treatments given until your account is paid in full.

I have read the Cancellation Policy for Rose Family Chiropractic, and agree to the terms stated above.

Name.....

Signature..... Date.....

We thank you for your courtesy in advance