CHIROFAMILY
CHIROSPORTS

Welcome to Chirofamily/Sports

At Chirofamily/Sports our goal is to optimise your health and increase your quality of life. Chiropractic is an approach to health and wellbeing that assists the body's own natural ability to function and heal itself.

The body loses its ability to self heal when there are problems with:

+ STRUCTURE (joint misalignment, nerve irritation, muscle spasm)

+ EMOTIONS (stress and past trauma)

+ NUTRITION (insufficiency, malabsorption, toxicity)

Therefore it is important when filling in the history form to be as thorough and specific as possible with all areas of your health.

At Chirofamily/Sports we define **HEALTH** as a state of optimal physical, mental and social wellbeing, not merely the absence of disease or pain.

We specialise in correcting **JOINT SUBLUXATION**, which is a misalignment of one or more joints, causing alteration of nerve function flow. Altered nerve function can lead to pain and organ dysfunction.

Some **CAUSES OF SUBLUXATIONS** include the birth process, accidents, falls, faulty posture and ergonomics, stress, significant emotional trauma, sleeping habits and dietary factors.

We correct subluxations with an **ADJUSTMENT** by applying gentle specific forces.

During your chiropractic history, examination, x-rays (if required) and continued chiropractic care, we may become aware of health issues beyond the scope of our expertise. If this is the case we have an extensive network of health professionals that we work closely with to ensure the best individual health results are achieved for you.

Please feel free to ask as many questions as you like. Our team is here to serve you.

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Office Fee Schedule and Financial Policy

SERVICE	FEES	CONCESSION
Initial Consultation & Examination	$138	$113
Report of Findings	$88	$83
Long Consultations	$88	$83
X-Rays (Private Health Fund rebates may apply)	$106	$106
Standard Adjustment	$71	$63
Foot Scan & Adjustment	$88	$83
12 Pack – Pre Pay	$766	$704
24 Pack – Pre Pay	$1490	$1370

FINANCIAL POLICY AND CHIROPRACTIC CARE PLANS

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic care package in advance.

12 PACK

To save time and money, we offer both a 12-pack and 24-pack pre-payment option for individuals, couples, children, seniors and families. These pre-payment packages are an option to pre-pay for your care, share savings in your family and are designed to be highly cost effective saving hundreds of dollars. Details of these plans will be discussed during your chiropractic report. For health insurance claiming purposes, when the pack is completed we provide you with a statement for your health fund so you can make your claim and receive eligible rebates. Health Funds pay claims for care received, not payment made in advance. If you wish to discontinue care at any time, we will happily refund your payment minus the care already received at the full scheduled fee per visit.

CANCELLATION AND RESCHEDULE POLICY

We require at least 6 business hours notice for cancellations and reschedules. As we are a busy practice, last minute changes often mean that someone else misses out on care. By giving us sufficient notice you enable us to offer your appointment time to someone on our waiting list. This makes for a happy, well-adjusted community. Charges apply for cancellations and reschedules with less than 6 hours notice. It is important to us that we treat you and all of our clients with our highest level of care and attention at all times, so this policy applies to everyone.

PRIVACY POLICY

Chirosports and Chirofamily Coogee is committed to providing quality health care for its clients. As a fundamental part of this commitment, principals and staff of the practice recognise the importance of ensuring that our clients are fully informed and involved in their health care. Our Privacy Policy and information on how to access your health care record can be found on our website at www.chirofamily.com.au

I, (name) _____ have read and I understand the above policies.

Patient signature _____ Date / /

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Confidential Patient Information

Thank you for allowing us to be involved in the improvement of your health and wellbeing!
It is essential that you complete the following questions to the best of your ability.
These questions are all relevant to your health and our proposed Chiropractic Care Plan.

Who may we thank for referring you?

YOUR DETAILS

Your name Date / /

Address Suburb

Post Code Email address

Mobile phone Home Work

Date of birth / / Occupation

Marital status M | S | D | W Pregnant Yes ☐ No ☐ Partners name

Names & ages of children

Private Health Fund

Doctors name & address

YOUR HEALTH PROFILE

What is your presenting complaint?

When did this problem begin?

How did it begin?

What makes it better?

What makes it worse?

Have you had it before? Yes ☐ No ☐ How many times? Last time:

What caused the problem in the past?

Is the problem stopping you from doing anything? Yes ☐ No ☐ If so, please list:

Have you seen anyone else for this problem? Yes ☐ No ☐ If so, whom and what was the outcome:

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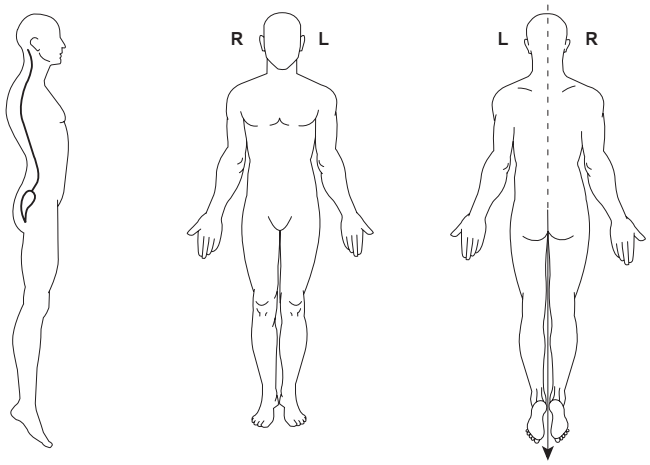
Please indicate on the diagram where you feel your discomfort:



List **any** medication/vitamins you are taking and what they are for?

List **any** operation, surgical procedures, major tests you have had, with dates:

1. Type When?

2. Type When?

List **any** past accidents, injuries, broken bones you have had, with dates:

1. Type When?

2. Type When?

List **any** past X-rays, CT's, MRI's you have had, what part of the body?

Where and when?

Do you exercise regularly? Yes ☐ No ☐ If so, what type/how often?

Do you have a personal trainer or go to a fitness class? (pilates, yoga, group training) Yes ☐ No ☐

Contact details of ☐ Trainer ☐ Coach ☐ Teacher

Do you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐ if so, how much/often?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Please indicate on the following scale how you are feeling at the moment:

	1 being WORST ever felt									**10 being BEST ever felt**
Presenting Symptoms	1	2	3	4	5	6	7	8	9	10
Pain Level	1	2	3	4	5	6	7	8	9	10
General Wellbeing	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
Energy Levels	1	2	3	4	5	6	7	8	9	10
Overall, how do you feel?	1	2	3	4	5	6	7	8	9	10

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Please tick if you have suffered any of the following recently or on a regular basis:

Dizziness	☐	Unexplained Weight Loss	☐	Headaches	☐
Fainting	☐	High Blood Pressure	☐	Migraines	☐
Difficulty Swallowing	☐	Fatigue	☐	Back Pain	☐
Visual Problems	☐	Sleeping Problems	☐	Loss of Balance	☐
Nausea	☐	Depression	☐	Stomach Problems	☐
Numbness	☐	Loss of Smell	☐	Heart Burn	☐
Pins and Needles	☐	Buzzing / Ringing in ears	☐	Ulcers	☐
Difficulty Talking	☐	Neck Pain / Stiffness	☐	Menstrual Problems	☐
Night Sweats	☐	Constipation	☐	Hot Flushes	☐
Inflammatory Arthritis	☐	Diarrhoea	☐	Frequent Coughs / Colds	☐
Asthma	☐	Allergies	☐	Frequent Ear Infections	☐
Scoliosis	☐	Seizures	☐	Tonsillitis	☐

STRESSORS

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

a.

b.

c.

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

a.

b.

c.

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

a.

b.

c.

What are your short term health goals?

What are your long term health goals?

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YOUR CONSENT

At Chirofamily/Sports we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know.

I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns they can be discussed with my chiropractor. I appreciate that I will receive the best care possible at CHIROFAMILY/SPORTS but that results cannot be guaranteed. I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Patients Signature Date / /

Chirofamily/Sports provides an appointment reminder service by SMS and may also communicate with you by SMS and email from time to time. All clients are automatically enrolled in this service. If you do not wish to have this service please indicate:

☐ *Please do not send me appointment reminders by SMS*
☐ *Please do not send me communications by email*