Trinity Chiropractic

Your health. Your choices. Your life.

CONFIDENTIAL HEALTH AND WELLNESS QUESTIONNAIRE

Our team believes that health is more than just how you feel. True health and wellness means you are physically, mentally and emotionally at your best.

ABOUT YOU

Full name ______________________________ Date ____________

Address ____

____ Postcode ________

Telephone H ____________ W ____________ M ____________

Email ____

Date of birth ____________ Age ____________

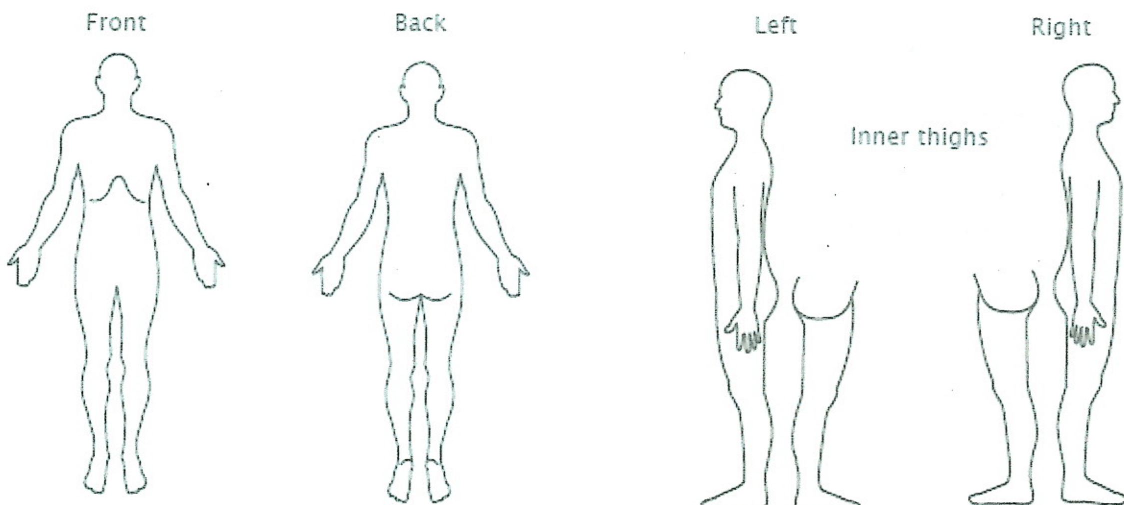
Your occupation ____

What do you enjoy doing most in life? ______________________________

CURRENT HEALTH

Do you have any health challenges currently? ______________________________

Please mark below any areas of concern, pain or discomfort.



How long have you had this problem? ________________ Have you had this before? __________

Have you sought any treatment for this/these issues? ________________________________

What treatment did you use? ____

What medications are you currently taking? ___________________________________

PAST HEALTH HISTORY

Please mark the following conditions you may have had or have now.

☐ Heart disease	☐ Epilepsy	☐ Sinus problems	☐ Concussion
☐ High blood pressure	☐ Eczema	☐ Low immunity	☐ Arthritis
☐ Breathing difficulty	☐ Thyroid problems	☐ Dizziness	☐ Allergies
☐ Asthma	☐ Neck pain	☐ Ringing in ears	☐ Fracture
☐ Digestive complaints	☐ Mid back pain	☐ Depression	☐ Cancer
☐ Numbness/Tingling	☐ Low back pain	☐ Anxiety	☐
☐ Diabetes	☐ Headaches/Migraines	☐ Low energy	☐

Have you had any major accidents, injuries or illnesses? ___________________________

____

____

LIFESTYLE

How many times on average do you exercise? ______________________________

What do you normally do? ____

Briefly describe your regular diet? ______________________________________

How much water do you drink in a day? __________________________________

How many hours do you sleep a night? ___________________________________

Do you wake feeling refreshed? _______________________________________

INFORMED CONSENT

I consent to a professional and complete chiropractic examination and any care the chiropractor deems necessary. I consent for my information being shared within the practice.

Print your name: ______________________________

Signature: ______________________________

Trinity Chiropractic

9 Oak River Drive, RD 5 Warkworth 0985
Phone (09) 422 7917

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical

and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

______________________________ Name (Please Print)

______________________________ Date: ______________ 20____
Signature of patient

______________________________ Date: ______________ 20____
Signature of Chiropractor

Trinity Chiropractic
Information Release

Authorization for Release of Patient Information

I ______________________________, do hereby authorize the release of the following information:

All viewable images and imaging reports, from your medical or other Health Care Facility, deemed relevant to the provision of chiropractic care at Trinity Chiropractic at the discretion of Dr. Lindsay Best and whoever may be designated as assistants.

________ other, to include:

To the firm Trinity Chiropractic, as listed above.

I hereby release the Health Care Facility authorized to release information as named above, its employees and agents, from any and all claims whatsoever which may arise as a result of the release of the above information.

I am eighteen years of age or older.

______________________________ Dated: ____________________
Patient's Signature