HEALTH PROFILE UPDATE

PATIENT PERSONAL INFORMATION

Given Name:_________________________ Surname:__________________________ DOB:___________________________

Please circle title: Dr / Mr / Mrs / Ms / Miss / Master / Other: _____________ Preferred Name: __________________________

Address:____

Phone Numbers: Home:_______________________ Mobile:_________________________Work:__________________________

Email Address:____ Occupation:______________________________

Emergency Contact: FullName:______________________ _______ Ph:_________________________ Relation:________________

Health Fund Name:________________________________ Membership Number: ____________________________________

Pension Concession/ Health Care Card #:____________________________________ Expiry Date:__________________________

DVA Number: ___________________________ GOLD card / WHITE card (please circle)

PATIENT HEALTH HISTORY UPDATE

Our records show that your last visit at our clinic was on: / /

Have any of the following occurred since your last visit?(Tick if applicable)

- ☐ Car accidents
- ☐ Falls
- ☐ Operations/ Surgeries
- ☐ Illnesses
- ☐ Been Hospitalised
- ☐ Any other forms of treatment
- ☐ Changes in medication
- ☐ Pregnancy
- ☐ Any other health changes

Explain:

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____

Describe your present health complaint?

____

____

How long has the problem been present? ____

Is the problem getting better / worse / staying the same? (Please circle)

If pain is present how would you rate you current pain level?

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

INFORMED CONSENT AND POLICIES ON FEES AND GUARANTEES

☐ I acknowledge that I have previously signed a "Consent to Proceed with Chiropractic Care" form on / / and continue to consent to care from all chiropractors consulting at Davis Chiropractic.

1. I understand that missed appointments may incur a fee. This clinic does not run accounts and payment for service is required at the time of consultation.
2. I appreciate that positive results of any treatment that I receive **are not guaranteed**.
3. I have read and agree that all information provided is accurate to the best of my knowledge. I also agree that it is my responsibility to inform the treating chiropractor within the clinic if any of the above information changes.

Signature: ____ Date: __________________________________