back in balance
chiropractic • physiotherapy • acupuncture

www.backinbalancechiro.co.nz

WELCOME TO BACK IN BALANCE

Full Name:_____Date of Birth:____/____/____

Full Address: _____

E-mail: _____Mobile Number: _____

Occupation:_____Employer Name:_____

Employer Address:_____Height:____m Weight:____Kg

Previous Acupuncture/Chiropractic/Physiotherapy care?_____

Do you have Southern Cross medical insurance? If yes, please provide member number_____

How did you find out about us (please circle): Existing patient/Sign/ Google/Facebook other:_____

24hr cancellation policy: We require at least 24hrs notice of any change of appointment or cancellation. Last minute cancellation/changes represent a loss of time. We offer a free txt and e-mail appointment reminder. Missed appointments or cancellations less than 24hrs will attract a $40 fee and this applies to ACC visits too as ACC do not pay us for missed visits. I understand & agree to this policy. Please tick ☐

What is your main complaint/reason for coming in today?_____

_____

Have you had a recent ACC injury? Bump/Fall/Accident?_____

Do you suffer from foot pain/ bunions/shin splints/calf pain/knee pain/hip pain/Other:?_____

How would you describe your posture? (e.g. hunched, normal, weak, lopsided):_____

Are you currently on any medication/supplements? Yes/No Please list:_____

_____

Have you ever been hospitalised or had surgery? Yes/No Please list:_____

Is there any further information you would like us to know?_____

In the past few months have you experienced any of the following? (please circle any that apply)
Unexplained changes in weight / Observable changes in moles or skin / Change in bowel or bladder habits / Pain at night / Sore that won't heal / Nagging cough / Unexplained Night sweats

Have you ever suffered a heart attack or had a stroke? Yes/No _____

Do you have any relevant long-term medical condition or communicable diseases? E.g. diabetes, heart condition, haemophilia, epilepsy, seizures, hepatitis, HIV or skin deseases_____

Females only: Is there a possibility you may be pregnant. Yes/No, if yes how many weeks _____

This is a consent form for Chiropractic/Acupuncture/Physiotherapy care

- Chiropractic is a process that involves the adjustment of your spine to improve spinal function and in turn reduce irritation to your nervous system. The nervous system impacts on every muscle, organ and tissue in your body and for this reason it is necessary to complete a full orthopaedic and neurological assessment.

- Chiropractic/Acupuncture/Physiotherapy process involves:
  1. An interview, which will include your complete health history.
  2. An orthopaedic and neurological examination.
  3. Due to nature of the treatment the practitioner may need to touch or palpate different areas on your body, this helps in the diagnosis or in locating acupuncture or chiropractic points.
  4. X-rays – if deemed necessary.
- You may be asked to remove certain items of clothing to enable better access to different parts of your body. You can expect to have a towel or blanket to cover yourself.
- If you feel uncomfortable in any way at any stage of the treatment for any reason please let us know immediately!
- You may experience some Bleeding, Bruising, Swelling, Numbness, Tightness or Tiredness after Acupuncture.
- All procedures will be clearly explained prior to treatment.
- You have the right to decline or withdraw your consent to treatment at any time.
- It is required that you inform us about any communicable disease (Hepatitis B and AIDS) or skin disease you are suffering from or history of haemophilia, allergies, epilepsy or seizures prior to treatment.
- I consent for the collection and passing of information between other health professionals if it is necessary in terms of the Privacy Act 1993 and the Health information Privacy Code 1994.
- Written consent from guardian or parent to be obtained before treating minors. (under 18 years)

Signature:_____Date:_____

N.b. Parent/Guardian to sign if under 18 years old.

ACC injury claim consent. I authorise:

The treatment provider to lodge this claim for me, ACC to collect and release relevant information about my claim to the extent needed to determine cover and/or assess my entitlement to financial compensation; rehabilitation assistance (including medical treatment) and/or the appropriate level of care and personal attention that I should receive; and/or to assist the evaluation of services and the performance of the ACC Scheme; and/or to detect the misuse of ACC assistance; and/or to support the administration of the Health and Safety in Employment Act 1992.ACC to collect and release relevant information from my claim for the purposes of research into injury prevention, accurate needs assessments and effective rehabilitation. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners; specialists; New Zealand Police; treatment providers; assessment agencies; IRD; WINZ; employers; Occupational Safety and Health; or witnesses to my accident).
I declare: That the information given about me and this claim is true and correct and that I have not withheld any information likely to affect my application for assistance. I will inform ACC of any change in circumstances which may affect my entitlements.

Signature:_____Date:_____

N.b. Parent/Guardian to sign if under 18 years old.