Australian Chiropractic College

INTAKE FORM - ADULT

Welcome to the ACC Chiropractic Centre

Client Personal Information

Name: Today's Date:

Age: DOB: Preferred pronouns:

Occupation: Employment Status:

Ethnicity/Culture: Native Language:

Address:

Suburb: State: Postcode:

Home Phone:

Mobile Phone: Work Phone:

Email Address:

Permission to leave a message on your answering machine or send an SMS: Yes ☐ No ☐

Concession Card Holder Yes ☐ No ☐ Concession expiry:

Preferred Mode of contact:
SMS to Mobile Phone: ☐ Voicemail ☐ Message left on home answering machine ☐

Preferred Mode of contact to confirm appointments:
SMS to Mobile Phone: ☐ Voicemail ☐ Message left on home answering machine ☐

Emergency Contact / Next of Kin

Emergency Contact Name: Relationship:

Emergency Contact Phone Number:

Next of Kin: Relationship

Next of Kin Contact Phone Number:

Treating GP

Name: _____ **Address:** _____

Phone: _____ _____

How did you hear about us?

☐ Website ☐ Chiropractic Centre Client ☐ Chiropractor: _____

☐ Signage ☐ Specific Event: _____ ☐ ACC Employee: _____

☐ Contact with a specific ACC intern or student: _____

Your medical record is a confidential document. It is the policy of this centre to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff.

Australian Chiropractic College: Level 2, 83-89 Currie Street, Adelaide SA 5000 Ph: 08 7082 1500, Email: admin@acc.sa.edu.au

Australian Chiropractic College

INTAKE FORM - ADULT

Client Consent to Share of Information

Australian Chiropractic College is an educational institution. At times, client files may need to be discussed between Chiropractic Centre Clinicians and Interns to ensure that you receive optimum care. Year 1 and Year 2 Chiropractic Students are required to observe, so may be present during your visit.

From time to time the College takes photographs of staff, clinicians, clients, and students to record activities within the College. These photos will be used responsibly, and measures will be taken to avoid personal identification. Please advise the College if you have any concerns about publication of your photos.

Video assessments may be used for the purposes of teaching and ongoing training. Videos are not made public, and clients are not identified.

Data collection may take place through student evaluations, client feedback, and client records for research purposes. Individuals will not be identified. This research may be published and held by the College in perpetuity. The supply of the information is voluntary except where required for funding and/or government reporting purposes.

I understand that the information given to my chiropractic intern/clinician during my consultation is recorded by the chiropractic intern/clinician in my healthcare file. I give permission for information in my file to be forwarded to other medical or healthcare providers if it is seen to be necessary for my health. I understand that all information in my file can only be accessed in agreement with my treating intern/clinician on the basis that confidentiality and protection of privacy is assured.

I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent for Share of Information above.

Client Signature: _____ Date: ____/____/____
Custodial parent or legal guardian if client is a minor

Relationship to client (if minor): _____

Intern Signature: _____ Date: ____/____/____

Clinician Signature: _____ Date: ____/____/____

Consent to Request Information

In order to obtain a complete health history, it may be necessary for my attending intern to request information from other health care professionals or previous chiropractor.

I, _____, do hereby provide authorisation for this to take place.
Please print full name

Client Signature: _____ Date: ____/____/____
Custodial parent or legal guardian if client is a minor

CLIENT HEALTH HISTORY

Client Name:_____ Date: _____

People consult our Chiropractic Centre with varied health objectives. Please indicate below with a "tick" which apply to you.

- ☐ Relief of symptoms
- ☐ Correction of my underlying problem
- ☐ Better perform work or recreational activities
- ☐ Improve my health and enhance my quality of life
- ☐ Maximise my own, my family's and my community's health

Is your appointment today as a result of a recent accident or injury? Yes / No

Please specify your main area of concern: _____

_____

_____

_____

Please specify any other health problems: _____

_____

_____

_____

Please state whether there are certain activities you would like assistance improving: _____

_____

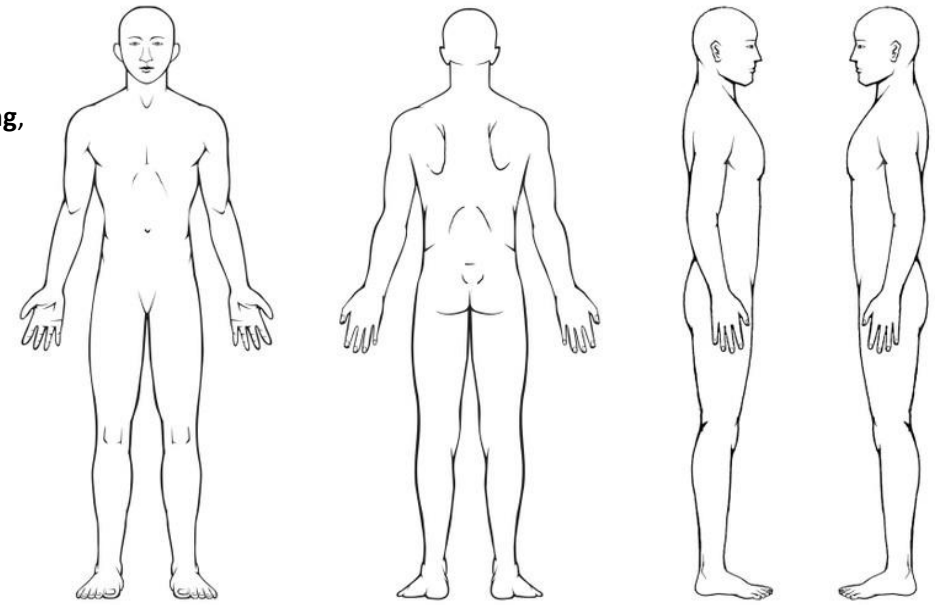
_____

If you experience **pain, numbness, or tingling**, please mark the areas on diagrams with:

P for pain and give it a mark from 1 – 10
(1 being slight and 10 being unbearable pain)

N for numbness and

T for tingling



FRONT BACK RIGHT LEFT

Intern initials: _____Clinical Supervisor initials: _____

File: **Health History 2023**

CLIENT HEALTH HISTORY

Client Name:_____ Date: _____

Please circle each individual answer and provide additional information when indicated.
Include both ***past*** and ***present*** conditions.
Please return the completed form to the front desk when completed

Family History

001: Y N High blood pressure
002: Y N Heart disease, type: _____
003: Y N Stroke
004: Y N Cancer, type: _____
005: Y N Musculoskeletal disease, type:_____
006: Y N Other family illness history:
_____
_____
_____

Patient's Current General History

007: Y N Recent weight change ↑ or ↓
008: Y N On-going fever / chills
009: Y N Periodic unexplained sweats
010: Y N Re-occurring allergies
011: Y N Anaemia
012: Y N Bleeding / bruising
013: Y N Malaise / fatigue / weakness
014: Y N Immuno-deficient condition
015: Y N Cancer

Endocrine History

016: Y N Heat / cold intolerance
017: Y N Thyroid conditions
018: Y N Diabetes

Eye / Ear / Nose / Throat

019: Y N Corrective lenses
020: Y N Eye redness, swelling, tearing, pain or itching
021: Y N Other visual conditions
022: Y N Difficulty hearing / deafness / ringing in ears
023: Y N Ear growths / discharge / pain
024: Y N Change in ability to smell or taste
025: Y N Nose growths / discharge / bleeding / pain
026: Y N Sinus conditions
027: Y N Hoarseness
028: Y N Difficulty chewing or swallowing
029: Y N Enlarged / painful glands
030: Y N Growths / lesions in mouth or throat

Gastrointestinal System

031: Y N Change in appetite
032: Y N Food intolerance
033: Y N Nausea / vomiting
034: Y N Indigestion / heartburn / excessive belching / gas
035: Y N Abdominal pain or swelling
036: Y N Change in bowel habits or stool (colour, consistency etc.)
037: Y N Hernia
038: Y N Haemorrhoids
039: Y N Gallbladder / liver / pancreas disease
040: Y N Liver disease

Respiratory System

041: Y N Difficulty breathing / wheezing / asthma
042: Y N Coughing / sneezing
043: Y N Tuberculosis / TB exposure
Date: _____
044: Y N Respiratory infections: COVID, pneumonia, etc
045: Y N Exposure to dangerous fumes, toxic chemicals, or excessive pollution
Date & type: _____

Cardiovascular System

046: Y N Chest discomfort / pain
047: Y N Palpitations
048: Y N Swelling / oedema
049: Y N Cold hand / feet
050: Y N Fainting
051: Y N High blood pressure
052: Y N Heart disease (past / current)
053: Y N Rheumatic fever

CLIENT HEALTH HISTORY

Client Name:_____ Date: _____

Urinary System

054: Y N Frequent urination
055: Y N Increased thirst
056: Y N Urinary urgency / pain / hesitancy / discharge / dribbling
057: Y N Urinary tract infections
058: Y N Kidney disease / stones
059: Y N Flank (side) / pelvic pain

Skin / Hair / Nails

060: Y N Change in skin texture / colouration
061: Y N Mole changes
062: Y N Change in hair / finger or toe nails

Breasts (Male and Female)

063: Y N Breast lumps / mass / growths / pain / tenderness / dimples
064: Y N Nipple discharge / bleeding

Reproductive System

Sex at birth: _____

(Male only)

065: Y N Erectile dysfunction

(Female only)

066: Y N Heavy / painful / irregular periods
067: Y N Menopause
068: Y N Diagnosed reproductive conditions
069: Y N Are you currently pregnant?
070: Y N Fertility issues

Neurological System

071: Y N Headaches
072: Y N Seizures / epilepsy / involuntary twitches
073: Y N Dizziness / fainting
074: Y N Numbness / tingling
075: Y N Limb weakness
076: Y N Head trauma / concussion
077: Y N Stroke
078: Y N Disc injury
079: Y N Other neurological conditions

Musculoskeletal System

080: Y N Joint stiffness / pain / swelling
081: Y N Muscle cramps
082: Y N Neck pain
083: Y N Upper back pain / mid back pain
084: Y N Low back pain
085: Y N Buttock / groin pain
086: Y N Upper limb condition
087: Y N Lower limb condition
088: Y N Fractures / dislocation / sprains
089: Y N Other injuries – include auto accidents, sports injuries and work-related accidents
090: Y N Other musculoskeletal conditions:
Type: _____

Hospital / Surgery / Medications

091: Y N Implants / supports (including heel lifts)
092: Y N Cardiac (pacemaker, etc.)
093: Y N Have you had any other hospitalisation or surgery?
094: Y N Current prescribed medications

Medication Reason

_____
_____
_____
_____

095: Y N Non-prescribed medications or drugs (including over-the-counter or recreational)

Medication Reason

_____
_____

Psychological History

096: Y N Anxiety
097: Y N Depression
098: Y N Hospitalization for psychological care
099: Y N Other psychological conditions:
_____

100: Over the last 2 weeks how often have you been bothered by the following problems:

100.1 Feeling nervous, anxious or on edge
❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

100.2 Not being able to stop or control worrying
❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

100.3 Little interest or pleasure in doing things
❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

100.4 Feeling down, depressed, or hopeless
❑*Nil* ❑*Some days* ❑*½ the week.* ❑*Most of the week*

CLIENT HEALTH HISTORY

Client Name:_____ Date: _____

Lifestyle

101: Y N Do you eat a healthy diet?

102: Y N Have an unusual appetite?
❑ large ❑ small

103: Y N Consume caffeine?
Frequency _____/day or week

104: Y N Consume alcohol?
Frequency _____/day or week

105: Y N Consume water?
Frequency _____/day

106: Y N Eat junk food frequently?
Frequency _____ /day or week

107: Y N Exercise / sports activity
Frequency _____ /day or week

108: Y N Smoker? past / present

109: Y N Hobbies: _____

Other

110: Y N Is there anything else you think we need to know about you?

_____

_____

_____

I have reviewed and certify that all the information that I have reported above, is true to the best of my knowledge.

_____
Client Signature Date

HISTORY REVIEW

Intern Name: _____

_____
Intern Signature Date

Clinical Supervisor Name: _____

_____
Clinical Supervisor Signature Date

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

At the completion of the physical exam:

Are x-rays required based on history and physical exam findings?

☐ Yes / ☐ No

Views: ☐ Cervical ☐ Thoracic ☐ Lumbar

Other: _____

Indicators:

Clinical Supervisor Signature:

_____