Australian Chiropractic College

INTAKE FORM

Welcome to the ACC Chiropractic Centre

Client Personal Information

Name: Today's Date:

Age: DOB: Preferred pronouns:

Height: Weight:

Occupation: Employment Status:

Ethnicity/Culture: Native Language:

Address:

Suburb: State: Postcode:

Home Phone:

Mobile Phone: Work Phone:

Email Address:

Concession Card Holder Yes ☐ No ☐ Concession expiry:

Preferred Mode of contact: Email: ☐ Phone call / Voicemail ☐

Preferred Mode of contact to confirm appointments: Email: ☐ Phone call / Voicemail ☐

Emergency Contact / Next of Kin

Emergency Contact Name: Relationship:

Emergency Contact Phone Number:

Next of Kin: Relationship:

Next of Kin Contact Phone Number:

Primary Healthcare Provider

Name: _____ **Address:** _____

Phone: _____ _____

Last time seen Primary Health Provider & for what reason _____

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: Ground Floor, 101 Grenfell St, Adelaide SA 5000 Ph: 08 7082 1500, Email: admin@acc.sa.edu.au

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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 Mentors 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 with your permission.

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 and their mentor during my consultation is recorded by the chiropractic intern/mentor in my client 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/mentor 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: ____/____/____

Parent to sign if client is under 18 years old

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Intern Name & Signature: _____ Date: ____/____/____

Clinician Name & 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/s.

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