The Healthpraxis - Faversham Chiropractic

Terms of Service.

As part of the examinations, you undergo at The Healthpraxis you will be offered a **digital structural screen**, which is completed via photos and analysed on an app. This analytics data includes aggregate human body measurements (range of motion angles, postural translations) but does not contain PII data (name, date of birth or address of any type). If you are a patient or client of a healthcare or other professional who is using this type of service, you must contact them (The Healthpraxis) directly and ask for your record information and or deletion. It is the sole responsibility of the healthcare professional that is utilising this type of service to maintain and comply with your requests on your personal electronic records.

Please sign here for consent _____

If you would like to receive additional information and newsletters via mail and email from the Healthpraxis please sign below. I will not share your email address with any third parties and information stored electronically is password protected. Please contact the Healthpraxis directly and ask for withdrawal from emails and or deletion of information.

Please sign here _____

Informed Consent.

There are some risks associated with any care and advice received here at The Healthpraxis family wellness centre. On occasion, people may feel sore, achy or tired after an examination, adjustment/entrainment or after implementing the advice given. This type of reaction typically resolves quickly as your body adapts and heals. Adjustments and Entrainments provided are in the form of low force touches and/or the more classical type of high-velocity low amplitude (HVLA) adjustment (which may or may not cause sounds known as audible releases) all of which will be applied to the areas in need of attention. Also, myofascial work may be used to alleviate undue stress on the body; education may be provided to help you build a better understanding of perception, rehabilitative and pre-habilitative exercises, breath control, mind-body strategies, and general health instruction. Your practitioner will evaluate your case, explain the care and a suggested care plan, this can also include referral to your general practitioner (Doctor) for consultation and/or further evaluation if deemed necessary.

Please sign here for consent _____

I understand that Chiropractic in this office is not a replacement for any care provided by other types of practitioners. I understand that I am not receiving care for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and neural integrity. I understand that diagnosis or treatment symptoms are a matter for Medical Professionals. I understand that seeking advice from another type of health care provider should not interfere with the care currently being provided by this office.

Please sign here for consent _____

Acknowledgement: I _____accept that in due time I will discuss or will be been given the opportunity to discuss with my practitioner the nature of the care at The Healthpraxis, alternatives to Chiropractic Care, my care plan in particular and the contents of this consent form. **Consent:** I consent to the Adjustments / Entrainments offered or recommended to me by my clinician, including, myofascial work, Adjustment / Entrainment or mobilisation to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic and understand that I must voice my concerns if this decision changes. **Declaration:** I confirm that the information provided in this form is true and correct to the best of my knowledge. I have read and understood the 'Privacy Policy' and 'Informed Consent' sections and agree to proceed with care.

Name: _____ Date: _____

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CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____

_____

Address _____

_____

Home Phone _____

Mobile Phone _____

Email _____

Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

NHS GP _____

_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

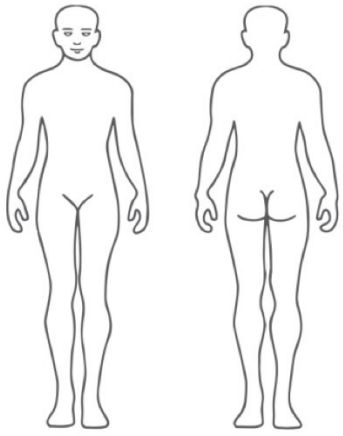
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

0 = NO SYMPTOMS; 10 = INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp

❑ Tingling ❑ Shooting

❑ Stiffness ❑ Burning

❑ Dull ❑ Throbbing

❑ Aching ❑ Stabbing

❑ Cramping ❑ Swelling

❑ Nagging ❑ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITTED; 10 = VERY COMMITTED

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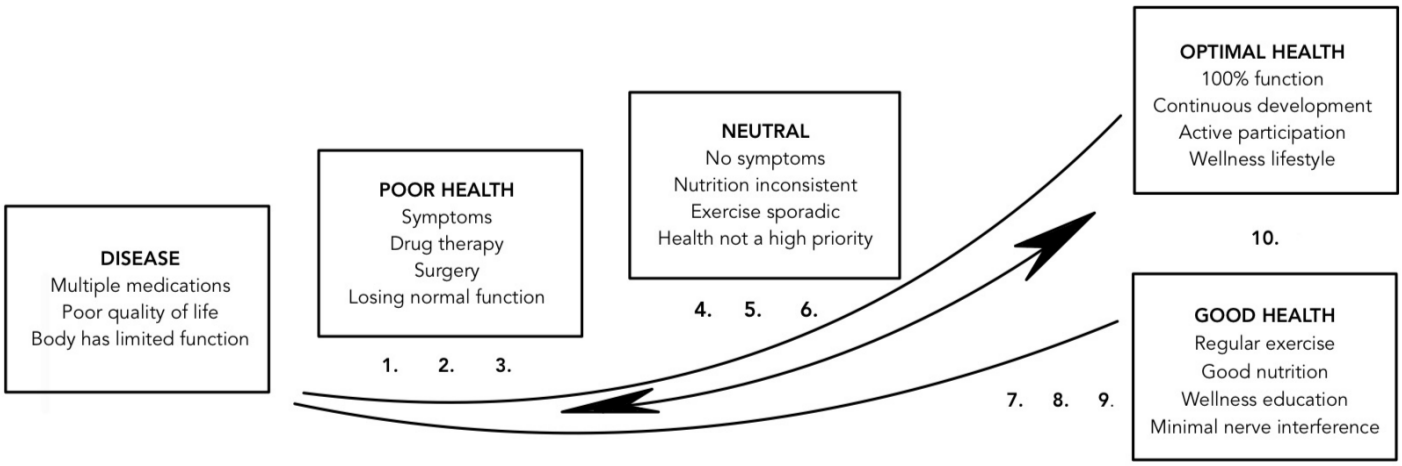
PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

1 year from now _____

5 years from now _____

10 years from now _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)