Welcome to hibiscus chiropractic

Important – please read.

It is important that you choose the right practitioner according to your own priorities & health goals. The three main types of chiropractors are described below:

Symptom Relief / Crisis Care Chiropractors

- Main goal is to relieve pain and/or symptoms.
- Similar in their approach to medical doctors and medications, as soon as the pain and or symptom is relieved, care is generally ceased.
- X-rays and other diagnostic tests are rarely performed.
- The number of treatments recommended is based on the degree of pain/symptoms and the level of insurance coverage.
- Often treatment is given at the first consultation.

Maintenance Chiropractors

- Will see the patient until they are out of pain and will then usually recommend some type of maintenance care to keep the pain away.
- X-rays maybe ordered at the beginning of treatment, followup x-rays rarely recommended.
- Treatment is often given at the first consultation.

Corrective / Wellness Chiropractors (What we are)

- Concerned with correcting the shape of the spine and improving the function of the nervous system.
- Focus on maximizing the health potential of the person and preventing future conditions.
- Use X-rays, postural assessment and other tests to determine the condition of the spine.
- Frequency of care is solely based on the severity of each individual case, ***not on the amount of pain or symptoms present.***
- Beyond correction, these chiropractors will continue to show patients how to achieve greater levels of health and wellness through ongoing lifestyle and chiropractic care.

Today's Consultation.

A comprehensive health & trauma history, postural assessment, structure tests and spinal x-rays if clinically indicated (taken at our Glenfield office). Normally $230

No treatment is given at first consultation.

AT the end of your consultation you will be booked in for your Report of Findings.

Your Report Of Findings.

Our doctors will present you with the results & clinical findings found during your examination. If able to accept your case our doctors will present you with the best recommendations for chiropractic care. We encourage spouses, partners, & parents to attend this report.

The first corrective adjustment will be performed at your request if the doctors are able to accept your case. This would be at an additional fee of up to $60.

Our office specializes in CORRECTIVE/WELLNESS chiropractic care.

Our goal is to provide our community with exceptional service, education and corrective chiropractic care. If you do not wish to proceed in our Corrective/Wellness Office, please inform a team member immediately.

I have read and understand the above.

Printed Name: _____ Date:

Signature: _____

HEALTH HISTORY FORM

Call or text 022 3914994
or email us at
hello@hibiscuschiropractic.co.nz

hibiscus chiropractic

PERSONAL INFORMATION

Name FIRST NAME _____
LAST NAME _____

Address _____

City _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑ M ❑ F Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Occupation _____

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? _____

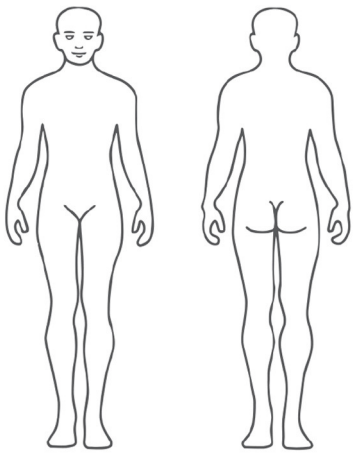
_____

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

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

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 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)

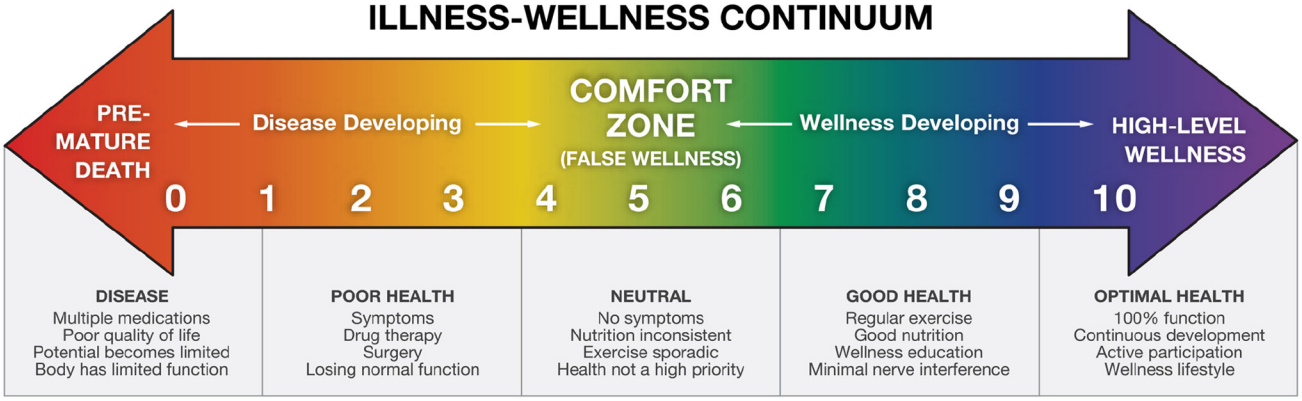
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other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

How committed are you to correcting this issue?

0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



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?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

HEALTH & ILLNESS HISTORY

Please mark the box beside any condition that you have currently (+) or have had in the past (–).

- ❑ 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 Health Concerns:

_____

_____

_____

_____

_____

_____

_____

_____

STRESSORS

Because accumulation of stress affects our health and ability to heal please list your top stresses - physical, chemical or emotional..

1.	When?	Hospitalized?	Yes ❑	No ❑
2.	When?	Hospitalized?	Yes ❑	No ❑
3.	When?	Hospitalized?	Yes ❑	No ❑
4.	When?	Hospitalized?	Yes ❑	No ❑

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? _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SUPPLEMENTS (list)

_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deffered to a later date.

Name: _____ **Signature:** _____ **Date:** _____