Dear Patient,

Stirling Health Professionals

Thank you for choosing Stirling Health Professionals for your spinal and health care. Please read through the following information.

What do I bring to my appointment? The Chiropractic Health Questionnaire form and Credit Card Authorisation completed. A list of any supplements or medication that you are currently taking. If you have any medical results from tests in the last 5 years, including x-rays, please bring these also.

Where can I park? 569 Karrinyup Road Stirling. We have plenty of free parking adjacent to the clinic. Closest Parallel Street is Dennis Street. We also have a bus stop located right in front of the clinic. Look for the orange flags.

How long does my first appointment last? Please allow approximately 45 minutes for your initial consultation, including time for any other forms to be filled in. Subsequent visits are approximately 10- 15 minutes.

What if I need to cancel my appointment? Failure to give 24 hour notice of cancellation of an appointment may attract a missed appointment fee.

Will I need x-rays? X-rays are not necessary in all cases but may be taken to assist the chiropractor in determining the best treatment. If we consider that x-rays are needed, these will be taken at the clinic, usually at the initial consultation. This applies to children as well, when required.

What are the costs involved? Initial consultations are $80.00, X-rays are $150.00. Standard consultations are $55.00, pensioner $50, junior $45.

Can I use private health? Yes we have HICAPS facilities. This means you can swipe your private health insurance card and will just be left with the gap to pay. You can ring your private health insurance to ask how much you will be eligible to receive off your consultation and/or x-ray.

What else is available at Stirling Health Professionals? We also have qualified Physiotherapists, Remedial Massage Therapists, a Podiatrist, Occupational Therapist and a Naturopath that work in partnership to provide you with the best health care possible.

Please email or fax us back with the attached questionnaire, alternatively bring it along with you to your appointment - admin@shpro.com.au or Fax 08 9446 8959

We look forward to helping you and if you have any queries please do not hesitate to call the clinic.

Yours in Health,

Stirling Health Professionals

569 KARRINYUP ROAD, STIRLING, W ESTERN AUSTRALIA 6021 TELEPHONE 61-8-9446 8322 FACSIMILE 61-8-9446 8959
EMAIL admin@shpro.com.au W EBSITE www.stirlinghealthprofessionals.com.au

SURNAME _____ GIVEN NAMES _____ DATE _____/_____/_____

WHO CAN WE THANK FOR REFERRAL? _____

YOUR FULL ADDRESS _____

_____ POST CODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE PHONE _____

EMAIL _____ IF YOU DO NOT WISH TO BE CONTACTED BY EMAIL, PLEASE TICK BOX ☐

AGE _____ BIRTH DATE _____ SEX MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐

OCCUPATION _____ ARE YOU IN A HEALTH FUND THAT COVERS CHIROPRACTIC CARE ☐

IF YES, WHICH FUND? _____ MEMBERSHIP NUMBER _____ REF NUMBER_____

Chiropractic Health Questionnaire

Symptoms related to the Nervous System

The nervous system's function is to control and co-ordinate all the other organs and structures. SPINAL FAULTS may interfere with this function and thus cause a wider variety of symptoms.

Chiropractic deals with the relationship between your spine and your nervous system

Have you suffered from any of the following (Tick appropriate box):

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	fertility issues	☐	☐	Hip pain or stiffness
☐	☐	stroke	☐	☐	Menstrual disorders	☐	☐	Buttock pain
☐	☐	Dizziness	☐	☐	Chronic fatigue syndrome	☐	☐	Leg pain
☐	☐	Sinus trouble	☐	☐	Sleeping problems	☐	☐	Leg cramps
☐	☐	Ear disorders	☐	☐	Jam/TMJ problems	☐	☐	Pins & needles of legs
☐	☐	Hay fever	☐	☐	Soreness in neck	☐	☐	Knee trouble
☐	☐	Recurrent sore throats	☐	☐	Shoulder pain/stiffness	☐	☐	Foot or ankle trouble
☐	☐	Asthma	☐	☐	Arm pain/weakness	☐	☐	Pins & needles of feet
☐	☐	Chronic cough	☐	☐	Elbow pain	☐	☐	Osteoporosis
☐	☐	Indigestion/reflux	☐	☐	Pins & needles of hands	☐	☐	Arthritis
☐	☐	Nausea/vomiting	☐	☐	Loss of grip/strength	☐	☐	Diabetes
☐	☐	Allergies	☐	☐	Wrist of hand pain	☐	☐	High blood pressure
☐	☐	Constipation	☐	☐	Mid back pain/stiffness	☐	☐	Chronic tension/stress
☐	☐	Irritable bowel syndrome	☐	☐	Pain in ribs	☐	☐	Loss of taste
☐	☐	Urinary disorders	☐	☐	Low back pain/stiffness	☐	☐	Significant weight loss/ Gain in short time period

PRESENT SYMPTOMS

What are your present symptoms? .....

Date of Onset: .....

Caused by? .....

Previous treatment by? .....

Result? .....

Has this occurred before and when? .....

Any family history of this problem? YES ❑ NO ❑

Is your major symptom aggravated by, or related to, your work? YES ❑ NO ❑

What medications are you taking and what are they for? (Include contraceptives) .....

.....

What serious illness have you had? .....

Do you sleep on Side ❑ Back ❑ Stomach ❑

How old is your mattress? ..... How many pillows and what type? .....

OTHER

If there is any other relevant information, please describe below:

.....

.....

.....

PREGNANCY

1. Is there any possibility that you might be pregnant? YES ❑ NO ❑
2. Please enter date of the first day of the last menstrual period / /

SIGNATURE

I, the undersigned, understand this clinic functions on a cash basis and I am financially obligated for any fees, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain re-imbursement from insuring companies.

I, understand that I am responsible for missed appointments and will pay fees relating to missed appointments.

Signature: _____