**PATIENT PERSONAL DETAILS**

Chiropractic Centre | New Zealand College of Chiropractic

The Chiropractic Centre is the training facility of the New Zealand College of Chiropractic.

You will be assessed and cared for by interns under the supervision of a registered chiropractor.

## Personal Information

Name: _____
*First* *Last* *Preferred name*

Date of birth: ___/___/_____ Age: _____ Sex: ❑ Female ❑ Male ❑ Other options

Address: _____
*Street* *Suburb* *City*

Phone: _____ E-mail: _____
*Home* *Mob/Alternate*

## We would like to know more about you

Marital status: _____ Ethnicity/culture: _____

Occupation: _____ Native language: _____

Hobbies: _____

Physical activities: _____

## Next of Kin / Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone number: *(BH)* _____

_____ *(AH)* _____

## Treating GP

Name: _____ Address: _____

Phone: _____ _____

Date & reason of last visit: _____

## Chiropractic Care

How did you hear about us?

❑ Website ❑ Chiropractor: _____

❑ Signage ❑ NZCC employee

❑ Chiropractic Centre patient ❑ Specific Event: _____

❑ Contact with a specific NZCC intern or student, name: _____

Is your presenting complaint a result of an accident or injury? ❑ No ❑ Yes

Have you previously received chiropractic care? ❑ No ❑ Yes

Reason for care: _____

Date of last visit: ___/___/_____ Were spinal x-rays taken? ❑ No ❑ Yes, date: ___/___/_____

Name of previous chiropractor/NZCC intern*: _____

**CONSENT FOR CARE AND SHARE OF INFORMATION**

Chiropractic care will not commence until this page has been completed.

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New Zealand College of Chiropractic is an educational institution. At times, patient 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.

From time to time the College takes photographs of staff, mentors, patients 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 patients are not identified.

Data collection may take place through student evaluations, patient feedback, and patient 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 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 Care and Share of Information above.**

Patient Signature: _____ Date: ___/___/___
*Custodial parent or legal guardian if patient is a minor*

Relationship to patient (if minor): _____

Witness by: _____ Date: ___/___/___

Intern Signature: _____ Date: ___/___/___

Mentor 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*

Patient Signature: _____ Date: ___/___/___
*Custodial parent or legal guardian if patient is a minor*