

## PATIENT PERSONAL DETAILS

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: \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Suburb City

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Home Mob/Alternate

### Next of Kin / Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
(BH)

\_\_\_\_\_ (AH)

### Treating GP

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date & reason of last visit: \_\_\_\_\_

### We would like to know more about you – optional questions

Occupation: \_\_\_\_\_ Ethnicity/culture: \_\_\_\_\_

Employment status: \_\_\_\_\_ Native language: \_\_\_\_\_

Children & their ages: \_\_\_\_\_

Hobbies & physical activities: \_\_\_\_\_

### 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.

Chiropractic  
Centre



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