

Have you had or do you have existing ailments (If so please give details):-

- Fractures _____
- Dislocations _____
- Major Accident's _____
- Medical Tests / Blood tests _____
- Surgery _____
- X-rays *Location of Scans* _____
- Medication _____
- Illness _____
- Infection / fever _____
- Smoking _____
- Recent GP visit _____
- Other _____

Have you previously, or do you currently experience any of the following conditions?

- | | | | | | | | |
|-------------------|--------------------------|-----------|--------------------------|--------------|--------------------------|-----------------------|--------------------------|
| Are you pregnant | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | Stroke / DVT | <input type="checkbox"/> | Blood/Heart Disorders | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Auto-Immune Disorder | <input type="checkbox"/> |
| Bowel/Bladder | <input type="checkbox"/> | Digestive | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | Sexual Dysfunction | <input type="checkbox"/> |
| Thyroid Disorders | <input type="checkbox"/> | Stress | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | Emotional Disorders | <input type="checkbox"/> |

Please give details: _____

Do you have a family history of Stroke Heart/ Blood disorders Cancer / Malignancy Diabetes Other

Please List _____

Consent To Treatment – Patient Information

Changes to the law now require all practitioners to advise patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke like symptoms. Studies indicate approximate risk ranges from 1.3 in 100,000 or 0.0013 % (Rothwell 2001) to 1 in 5.85 million or 0.0000001 % (Neck manipulations. Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to inform. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strains/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). [Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.]

Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Magna report, Ontario Ministry of Health, 1993)

If you have any questions related to the treatment you are about to receive, please speak with the practitioner.

You can choose other alternatives to this treatment, which might include; chiropractic without manual adjustment, no treatment, medicine, physical medicine, chiropractic, physiotherapy, acupuncture, massage or other: _____

I have discussed the above information with the Practitioner and understand the risk. I give my consent to treatment, which may include spinal adjustment. The information I have provided is correct and complete. In signing this document I agree to indemnify the Provider of this service and its employees, agents and representatives from claims made against them in the event that I react to the treatment provided.

We value your time and appreciate helping you with your Health care needs. Your appointment is important to us.

As missed appointments may inconvenience other patients, our clinic has employed a policy of charging a normal consultation fee for missed appointments and those appointments cancelled without 4 hours' notice. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

Print Full Name: _____ Patient's Signature(or Legal Guardian): _____

Date: / / 20

Entering your name in the box above acknowledges that you have read the form and consent to assessment and treatment.