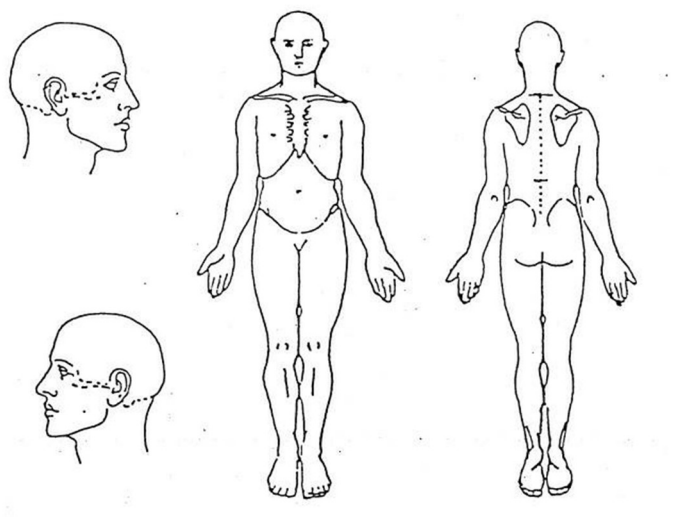
## PATIENT RECORD

Name:

Age: Occupation:

***PLEASE SHADE***



*Medical History:*

☐arthritis ☐cancers/tumours ☐migraines
☐stress/anxiety/depression ☐dizziness/vertigo
☐loss of vision ☐bowel/bladder ☐seizures
☐hearing disturbances ☐stroke/heart attack

*Medications*:

☐Blood pressure ☐Asthma medication
☐Cholesterol ☐Psychotropics
☐Diabetes ☐Contraceptive/HRT
☐Thyroid ☐Chemo/Radiation
☐Pain killers: _____

☐Supplements:_____

☐Other:_____

***Please describe your symptoms:***_____

_____

*Describe your health generally:* _____

*Allergies:* _____

*Surgeries/operations:* _____

*Family medical history:* _____

*Anything else we need to know about:*_____

## INFORMED CONSENT

**When performed by an appropriately qualified practitioner, spinal manipulation is an effective and safe method of treatment for many painful conditions. There are however risks associated with any treatment, and I am required to inform you of these**

I hereby request and consent to the performance of treatment on me by the authorised practitioner I have chosen or been assigned.
I understand that results are not guaranteed.
I understand, and I am informed that, as in the practice of medicine, in the practice of manual therapy there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, nerve injuries, strokes and stroke-like episodes.
I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgement during the course of the treatment, which the practitioner feels as the time, based upon the facts then known, is in my best interests.
I have had the opportunity to discuss the nature and purpose of treatment.
I intend this consent form to cover the entire course of treatment for my present condition, and for any other condition(s) for which I seek treatment.
I understand that I can withdraw my consent at any time.
I have read the above, and I have also had the opportunity to ask questions about its content.

Signature Date Signature Date

## PATIENT RECORD

### Personal Information:

*Title:* _____ *Given name:* _____ *Surname:* _____

*Preferred name:* _____

*Address:* _____*p/c*_____

*Date of Birth:*_____ *Occupation:* _____

*Mobile number:* _____*Home phone:* _____

*Email address:* _____

Do you have private health insurance? ☐Yes - Fund: _____ M'Ship# _____

Do you have Ambulance Membership? ☐Yes - M'Ship #:_____

Are you a serving member of ☐VicPol, ☐MFB/FRV, ☐CFA, ☐AV, ☐SES ?

Are you on a FULL pension? ☐Yes – CRN: _____ exp: _____

Is your treatment covered by: ☐TAC, ☐Workcover, ☐NDIS, ☐DVA, ☐Medicare ?

Claim No. _____ Date of injury:_____ Insurer: _____

Who is your regular GP? _____

*How did you hear about the clinic:* ☐Friend/relative (who?) _____
☐Internet search, ☐Yellow pages, ☐Facebook, ☐Instagram, ☐Drive by, ☐Newspaper, ☐Flyer, ☐Other _____

*We send our patients appointment reminders via SMS. Is this OK?* ☐ Yes ☐ No

*Are you happy to receive other marketing promotions including, but not limited to; birthday discounts, introductory offers, massage specials etc?* ☐ Yes ☐ No

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**PLEASE NOTE:**

We have a

**SIX HOUR**

cancellation policy

*-A fee may be charged for missed appointments-*

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*Don't forget to check in!*

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