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| --- | --- | --- | --- | --- |
| **NAME:** | | **DATE OF BIRTH:** | | **AGE:** |
| **ADDRESS:** | | | | |
| **CONTACT DETAILS MOBILE: HOME:** | | | | |
| **E-MAIL ADDRESS:** | | | **OCCUPATION:**  **CHILDREN:** | |
| **WHERE DID YOU HEAR ABOUT THE CLINIC:** | **GP NAME & CONTACT NO.:** | | | |
| **DESCRIBE YOUR CURRENT PROBLEM AND WHEN IT BEGAN:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HOW DID YOUR POBLEM BEGIN?**  **Quality:**  Dull / Sharp Stiffness Stabbing  Numbness Throbbing Pulling Sensation  Tingling Burning Aching  **Severity / Pain Scale:** 0 1 2 3 4 5 6 7 8 9 10  **What makes it worse:**  **What makes it better:**  **SHOE SIZE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | MARK AN **x** ON THIS PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS: | | |
| **How often are your symptoms present?** (Occasional) 0 – 25% 26 – 50% 51 – 75% 76-100% (Constant)  **In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)?**  0 1 2 3 4 5 6 7 8 9 10  No interference Unable to carry on any activities  **In general how would you say your overall health is right now:**  Excellent Very good Good Fair Poor  **Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint?**  No Yes  Date(s) taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What areas were taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please check all of the following that apply to you:**  Alcohol/Drug Dependence Prostate Problems  Recent Fever Menstrual Problems  Diabetes Urinary Problems  High Blood Pressure Currently pregnant, # weeks \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stroke (Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Abnormal Weight Gain Loss  Corticosteroid Use (Cortisone, Prednisone etc.) Marked Morning Pain/Stiffness  Taking Birth Control Pills Pain Unrelieved by Position or Rest  Dizziness / Fainting Pain at Night  Numbness in Groin/Buttocks Visual Disturbances  Cancer/Tumor (explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Osteoporosis Tobacco use – Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Epilepsy/Seizures Frequency:\_\_\_\_\_\_ \_\_\_\_\_day  Other Health Problems (explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications  **Family History:** Cancer Diabetes High Blood Pressure  Heart Problems/Stroke Rheumatoid Arthritis | | | | |

**CONSENT**

I consent to a physical examination by my Chiropractor, to included (as needed) foot examination and Gaitscan.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/ GUARDIAN (if under 18 consent must be given by parent or legal guardian.)

I confirm that I have received a full explanation, of the outcomes of the Chiropractor’s assessment and a diagnosis/rationale for care and proposed treatment plan; in terms that I can understand.

I have had the opportunity to ask questions in respect of my reason for attending a Chiropractor. I understand that it is my right to seek a second opinion, at any time; should I wish.

I have been advised of the care options, both Chiropractic and alternates, available to me and acknowledge that any decision to proceed, is based on a full understanding; of the likely benefits and any reasonably foreseeable risks of care. I understand that the outcomes of care, cannot be guaranteed.

I confirm that the financial implications of the proposed plan of care and any available options have been explained to me.

I hereby give consent to the Chiropractor, to retain my personal information, (under GDPR Guidelines); for the purpose of my healthcare.

I also confirm that, I am content, when the Chiropractor deems it necessary and appropriate, I consent for my Chiropractor to contact my general medical practitioner (GP) and for the Chiropractor, using any appropriate means; to discuss aspects of my health or care with my GP.

I understand that the chiropractic diagnosis and treatment plan proposed, is based on the information that I have given to the Chiropractor.

I understand that it is my right to decline care, or withdraw from care, or any aspects of care, at any time. I also understand that I am free to withdraw my consent, to aspects of care.

I understand that I must be committed to attend sessions, on a consistent basis to receive the greatest benefit from treatment. Although I may stop treatment at any time, I agree to inform the Chiropractor of my decision, so that you are aware of my intentions in good time, before the next appointment.

Based on the above, I freely and voluntarily consent to receiving chiropractic care.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/ GUARDIAN (if under 18 consent must be given by parent or legal guardian.)