|  |  |  |
| --- | --- | --- |
| **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 10No 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 YesDate(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.)