ROUGHAN CHIROPRACTIC CONSENT FORM

Mr/Mrs/Miss/Ms Surname: _____

First Name(s): _____

Known as: _____ Blood Type: A / O / B / AB

Address: _____

_____ Post Code: _____

Telephone: Home: _____ Work: _____ Mobile:_____

Email Address: _____

Occupation: _____ Employer: _____

Date of Birth: _____Age: _____ Sex: _____ Marital Status: _____ No. of Children: _____

Who may we thank for recommending you? _____

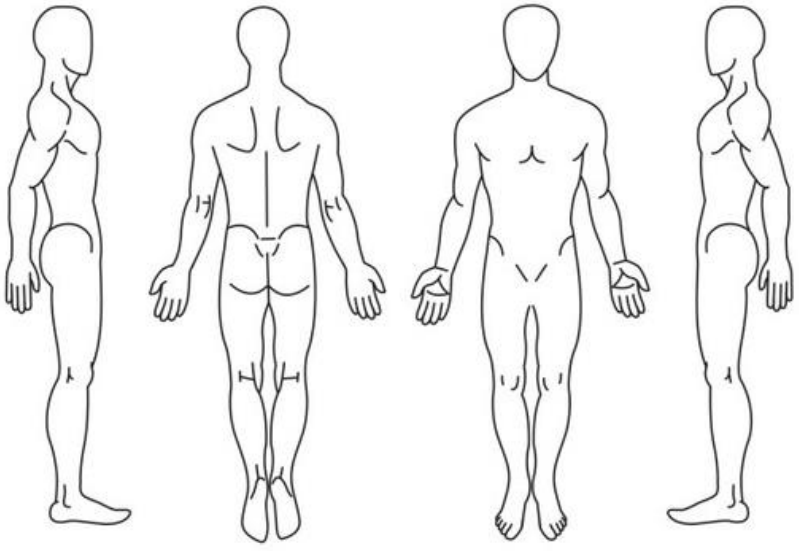
HOW CAN WE HELP YOU?

What brings you in today? _____

What symptoms are you experiencing? _____

How intense are your symptoms? (please circle) 0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please indicate on the diagram the areas where you are experiencing discomfort or pain and/or have any problems with regarding movement:



What does it feel like? (check where appropriate):	
❑ Numbness	❑ Sharp
❑ Tingling	❑ Shooting
❑ Stiffness	❑ Burning
❑ Dull	❑ Throbbing
❑ Aching	❑ Stabbing
❑ Cramping	❑ Swelling
❑ Nagging	❑ Other_____

Is this reason due to a specific accident or injury? Yes ☐ No ☐

HOW IS THIS AFFECTING YOU?

How is this symptom / condition interfering with your life? (check where appropriate)

	No effect	Mild effect	Moderate	Severe		No effect	Mild effect	Moderate	Severe
Work	❑	❑	❑	❑	**Energy**	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	**Attitude**	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	**Patience**	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	**Productivity**	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	**Creativity**	❑	❑	❑	❑

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED VERY COMMITTED

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HEALTH & ILLNESS HISTORY

Please mark the box beside any condition that you have currently (+) or have had in the past (-)

❑ AIDS/HIV	❑ Childhood Illness	❑ Headaches/Migraines	❑ PMS Pain	**Other Health Concerns**
❑ Alcoholism	❑ Depression	❑ Heart Disease	❑ Reproductive Issues	
❑ Anxiety	❑ Diabetes	❑ Hepatitis	❑ Ringing in Ears	
❑ Arteriosclerosis	❑ Digestive Issues	❑ Hip Issues	❑ Scoliosis	
❑ Arthritis	❑ Elbow Issues	❑ Immune Issues	❑ Sinus Infections	
❑ Asthma/Allergies	❑ Endocrine Issues	❑ Kidney Infection	❑ Shoulder Issues	
❑ Back Pain	❑ Foot/Ankle Issues	❑ Lymphatic Issues	❑ Stroke	
❑ Cardiovascular Issues	❑ Gall-bladder trouble	❑ Multiple Sclerosis	❑ TMJ/Jaw Issues	
❑ Cancer	❑ Gout	❑ Neck Pain	❑ Tremors	
❑ Circulation Issues	❑ Hand/Wrist Issues	❑ Osteoporosis	❑ Urinary Issues	

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS	SUPPLEMENTS

Physical / Structural

Have you ever……..	Yes	No	Describe Briefly
Been knocked unconscious?	❑	❑	_____
Used a cane, crutch, or other support?	❑	❑	_____
Been treated for a spine or nerve disorder?	❑	❑	_____
Had a fractured bone?	❑	❑	_____
Been hospitalized for other than surgery?	❑	❑	_____
Had previous back injuries?	❑	❑	_____
Do you have any artificial implants? E.g. joint replacement etc.	❑	❑	_____

Chemical / Nutritional

	Yes	No	Describe Briefly
Do you smoke?	❑	❑	_____
Do you drink alcohol?	❑	❑	_____
Are you being or have you been exposed to chemicals?	❑	❑	_____
Are you or have you ever taken non-prescription drugs?	❑	❑	_____

Mental / Emotional

	Yes	No	Describe Briefly
Can you name a significant traumatic emotional event?	❑	❑	_____

How do you feel you coped? _____

Have you experienced a loss in the past five years? (E.g. family, close friend, business, financials, relationship)

_____

_____

Lifestyle Habits

How many hours of sleep do you get on average? What time do you usually sleep? _____

What do you do for regular exercise? _____

Hobbies (what do you love doing): _____

Sports: _____

Care Plan Consent

❑ I hereby give my consent to Roughan Chiropractic practitioners to assess and adjust me, providing a full verbal explanation is given at the time of consultation. I understand I have the right to decline any and all treatment offered to me at any time. I understand the practitioner may discuss my care regime with other consultants at Roughan Chiropractic, in line with the practice's multidisciplinary approach.

Agreement to Pay

❑ I undertake to pay any charges that I incur. I understand all treatments are payable at time of visit. ***All charges not paid at time of visit incur an immediate $5 administration fee***.

Cancellation Policy

❑ Roughan Chiropractic is a busy practice. If for any reason you need to reschedule or cancel your appointment please note we require **24 hours notice** for all appointments; to avoid you being billed for a missed appointment. This, primarily is in consideration for others, and allows us to schedule in patients from our waiting list. Appointments cancelled without sufficient notice and missed appointments will be charged a ***No Show Fee of $40***.

Signature: _____Date: _____

Thank you for your cooperation ☺