Consent Forms

CONSENT TO EXAMINATION

To be completed by parent or legal guardian if under 16 years of age. I hereby confirm the information provided is accurate and authorise this clinic and its Doctor (s) to administer an examination as they deem necessary. I realise that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Signed: _____ Date: _____

PRIVACY POLICY CONSENT *Refer to our website for full policy wording* - **Please delete as appropriate:**

I consent / do not consent to Aberdeen Chiropractic Clinic using my contact information to send appointment reminders by telephone, email or SMS.

I consent / do not consent to receiving market information from Aberdeen Chiropractic Clinic

Signed: _____ Date: _____

Office use only:

CONSENT TO X-RAYS

Are you undergoing fertility treatment (males included)? _____

Are you or could you be pregnant? _____

When was the start of your last period? _____

Cervical	cm	KVP	mA	sec	**Lumbar**	cm	KVP	mA	sec	**Other**	cm	KVP	mA	sec
APOM														
AP														
LAT														
OBL R/L														

Notes: _____

Clinical criteria for X-rays: _____

I have been advised about the need for x-ray examination and give my consent**:**

Signed: _____ Date: _____

CONSENT TO CHIROPRACTIC CARE

I acknowledge that I have discussed or had the opportunity to discuss with my Chiropractor, the nature and purpose of Chiropractic Care in general and my management (including spinal adjustments).

I consent to the Chiropractic Care offered or recommended to me by my Chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future Chiropractic Care.

I understand that the information recorded in my files, x-rays or through any correspondence will remain in this clinic and will be treated with utmost confidence.

I have been fully informed of the symptoms, risk and necessary action if cauda equina symptoms occur, including consulting with A&E Dept.

To be completed by parent or legal guardian if under 16 years of age:

Signed: _____ Name (Please Print) _____ Date: _____

New Patient Intake Form

Aberdeen Chiropractic Clinic
your health & well being since 1979

Date: ( ) Practitioner: ( ) Service Type: ( ) Patient ID: ( )

Confidential Patient Information

To provide the most comprehensive care possible, our initial assessment explores all details of a person and their life, in that health issues are seldom associated with just one factor. This information will help us identify the root causes of your symptoms and formulate your care plan. So please be patient and fill in the questionnaire below.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Town: _____ Postcode: _____

Tel: (Home): _____ Tel: (Work) _____ Mobile: _____

Email: _____ Occupation: _____

Single / Married / Widowed / Divorced / Partner _____ No of Children: _____

Name of GP and Surgery _____

How did you hear about us? (eg. friend / family / internet / event / location) _____

Are you here because of a corporate agreement (If yes which company?) _____

Are you covered by private medical insurance? (If yes which company?) _____

Besides any spinal problems, how do you grade your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

What is your main health concern and when did it start? _____

Other practitioners seen for this condition (If yes, specify)? _____

Do you drink alcohol? How much and how often? _____

Do you take supplements? (Which/Dose) _____

Do you take medication and for which condition? _____

Have you ever taken antibiotics? (When and for what reason?) _____

Have you repetitively used pain killers or anti inflammatories? If so, when and for what reason?

_____

Have you had any major traumas/accidents/injuries in your life? _____

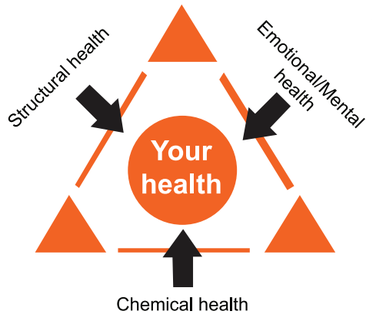
Have you had any surgeries? If so, when and for what reason? _____

Which 3 of your symptoms (If applicable) most concern you? _____

1. _____

2. _____

3. _____



Your total health complaints are influenced by the balance of your PHYSICAL, CHEMICAL and EMOTIONAL levels which dynamically influence each other and holistically sum up your total wellbeing.

On a scale of 0 (being the poorest) to 10 (being excellent), grade your:

Structural wellbeing (spine, muscles, fitness) _____

Chemical wellbeing (physiology, nutrition, environment) _____

Emotional wellbeing (stress, anxiety, depression) _____

If your condition involves pain or disability, complete the following diagram

Place symbols A, B, C, S, P, N on the diagram which correspond to the area of your present symptoms

A - Aching pain

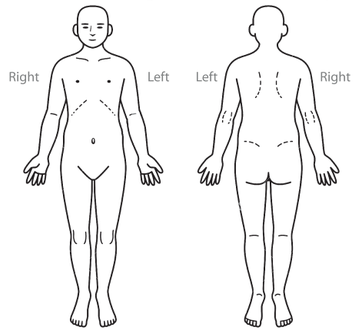
B - Burning pain

C - Cramping pain

S - Shooting pain

P - Pins and needles

N - Numbness



On a point scale of 0 (no pain) to 10 (excruciating pain), circle the number that represents your pain:

0 1 2 3 4 5 6 7 8 9 10

General Symptoms Questionnaire

Circle the symptoms you have now or in the last 2 months and underline the symptoms you have had in the past

RESPIRATORY/MOUTH

Chronic cough

Recurrent colds or flu

Chest congestion

Asthma/Wheezing

Bronchitis

Shortness of breath

Sore throat or hoarseness/Loss of voice

Mouth ulcers/Cold sores

Thrush

HEART/CARDIOVASCULAR

Irregular or skipped heartbeat

Rapid heartbeat/Palpitations

Chest pain

High blood pressure

Low blood pressure

Heart Condition

Stroke

Poor circulation/Raynaud's

Anaemia

Varicose veins

Tendency to bruise easily

Leg cramps

EAR/NOSE/THROAT

Itchy ears

Earaches/Ear infections

Discharge from ear

Ringing in ears (tinnitus)

Hearing loss

Sinus problems

Stuffy/Blocked nose

Hayfever/Sneezing attacks

Excessive mucus

Gagging

Frequent need to clear throat

NERVOUS-SYSTEM / MUSCULOSKELETAL

Low back pain

Neck pain

Shoulder pain

Arm/Elbow/Wrist/Hand pain

Hip/Knee pain

Ankle/Foot pain

Arthritis

Bursitis

Sciatica/Buttock/Leg pain

Swollen joints/Stiffness or limited movement

Numbness

Pins and Needles

Tremor

Muscle Ache/Pain

Weakness in arms/Legs/Hands

ENERGY/ACTIVITY LEVELS

Weakness in arms/Legs/Hands

Fatigue/Sluggishness

Apathy/Lethargy

Hyperactivity

Restlessness

HEAD / EYES

Headaches

Faintness

Dizziness

Watery or itchy eyes

Swollen, reddened or sticky eyelids

Bags or dark circles under the eyes

Blurred or Tunnel vision (does not include near or far sightedness and diagnosed conditions)

Failing vision

MENTAL WELLBEING

Poor memory

Confusion, poor comprehension

Mind/Body coordination

Poor concentration

Indecisive

Stuttering or stammering

Slurred speech

Learning difficulties

Insomnia

Mood swings

Anxiety/Fear/Nervousness

Anger/Irritability or aggressiveness

Stress/Panic attacks

Seizures

Depression

GENITO-URINARY

Thrush

Bladder issues

Bedwetting

Kidney infections

Kidney stones

Prostate issues

Menstrual issues

Breast lumps/Tenderness

Infertility/Miscarriage

Genital or anal itching or discharge

OTHER

Frequent illness

Cancer

Trauma

Widespread body pain or tenderness

DIGESTIVE SYSTEM

Nausea or vomiting

Diarrhoea

Constipation

Bloated feeling

Belching or flatulence

Heartburn/Reflux/Indigestion

Intestinal/Stomach pain

Stomach Ulcers

Haemorrhoids

WEIGHT/APPETITE

Binge eating/Drinking

Craving certain foods

Excessive weight gain

Excessive weight loss

Compulsive eating

Water retention

Diabetes

HORMONAL

Hormonal problems

Thyroid problems

SKIN

Acne

Hives, rashes or dry skin

Psoriasis/Eczema

Hair loss

Flushing or hot flushes

Excessive sweating or body odour

Athlete's foot

Other symptoms or diagnosed conditions:

_____

_____