

Confidential Patient Information

Patient First Name: Surname:
 Parents (if child): DOB:
 Address:
 Tel: (H) (W) (M)
 Email: Occupation:
 Marital Status (circle): Single De Facto Married Separated Divorced Partner Deceased
 How did you find out about us (who referred you)?

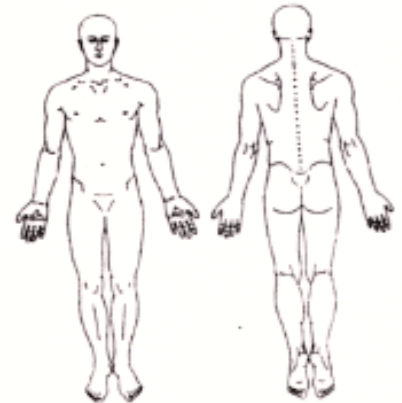
From time to time we would like to send you information about our clinic, such as newsletters. Do you consent to receiving such information?.....

1) Reasons for attending this clinic

Wellness ☐ Specific problem ☐ (explain below)

If relevant, also indicate the location of symptoms on the diagrams ▼

.....



Please complete questions 2 to 7 if you are attending due to a specific health problem:

- 2) When was the problem first noticed? 3) Has it worsened?
 4) What makes it worse? 5) What makes it better?
 6) Previous assessments or tests:
 7) Previous treatments:

Please provide detailed lists in your responses to questions 8 to 14 below:

- 8) Please list any specific illnesses or health problems that family members or relatives have suffered from:

 9) Please list any accidents or trauma that you have experienced in the past, and when:

 10) Please list any current or recent medications, supplements/herbals or social drugs that you have used:

 11) Please list any illnesses that you currently or previously experienced, and when:

 12) Please list any surgeries or hospitalisations that you required in the past:

13) Please list your usual sport, exercise and recreational activities:

.....

14) Have you ever smoked, and how much? Describe your alcohol use:

Please read the following information carefully before signing.

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation. I will also discuss any consultation fees with a health practitioner or staff member at this clinic prior to the service being provided.

2) I appreciate that **positive results of any treatment** that I receive at Beyond Chiropractic **is not guaranteed**.

3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

4) Information gained from the initial assessment and follow up sessions **may be used for internal research purposes** or **publishable research** to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details etc.) will be disclosed in any published material.

Risks of Care & Consent for Care:

5) Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications**. This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.

6) I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.

7) I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Patient's Signature (if 16 or older): **Date:**

Parent's Signature (if patient is under 18): **Date:**

Please print name/s here:

When completed, please return to **Beyond Chiropractic: 5 Inbhear Square, Templarainey, Arklow, Co Wicklow T: 0402 91133**

***** Please bring any previous reports, scans or test results that may be relevant for your assessment.**