DUNSBOROUGH OSTEOPATHY

PATIENT DETAILS

Surname: _____ First Name: _____ Preferred name: _____

Postal Address: _____ Post Code: _____

Phone: Home: _____ Work: _____ Mobile: _____

Date of Birth: _____ Age: _____ Occupation: _____

Who referred you? _____

Referring doctor's clinic and phone: _____

Referring doctor's address: _____

Please tick any of the following that apply in the past 3 months:

- o Numbness or weakness
- o Heavy dragging feeling in legs, tingling soles of feet
- o Sudden severe headache
- o Dizziness, nausea, vomiting or unstable walking
- o Temporary loss of consciousness
- o Pulsation in the chest or abdomen
- o Night pain
- o Unremitting pain
- o Pain that wakes from sleep
- o Back pain worse with rest
- o Rapid unexplained weight loss
- o Night sweats
- o Unexplained fever
- o Unusual bleeding
- o Change in bowel or bladder habits
- o Difficulty swallowing
- o Nagging cough
- o Visual changes, difficulty swallowing or changes in facial expression
- o Headache worse when lying down
- o Bruising not caused by trauma
- o Blood thinning medication
- o Immunosuppressant therapy
- o Recent trauma

Please tick if you (or immediate family members) have a past history of the following:

- o Inflammatory arthritis
- o Previous history of any cancer
- o Previous history of disc herniation, prolapse or spinal surgery
- o Diagnosed Osteoporosis or Osteopenia
- o Drug or alcohol addiction
- o Depression
- o High blood pressure
- o Corticosteroid use
- o Smoking

Medications (and the reason for taking):

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INFORMED CONSENT TO OSTEOPATHIC CARE

When performed by a qualified Osteopath, Spinal/Joint Manipulation, Myofascial therapy and Osteopathy in the Cranial Field are effective and safe methods of treatment for many painful conditions and general health concerns. There are, however, risks associated with any treatment, and I am required to inform you of these.

I hereby request and consent to the performance of Osteopathic treatment on me by David Bennett.

I understand that results are not guaranteed. I understand, and have been informed that as in the practice of Medicine, in the practice of Osteopathy there are some very slight risks to treatment, including, but not limited to post treatment fatigue or light headedness, emotional distress, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, stroke and stroke-like episodes.

I do not expect the Osteopath to be able to anticipate and explain all risks and complications, and I wish to rely on the Osteopath to exercise judgment during the course of the treatment, which the Osteopath feels at the time, based upon the facts known, is in my best interest.

I intend this consent form to cover the entire course of treatment for my present condition, and for any other future conditions(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

I have understood the above-mentioned risks associated with treatment.

Patient Name: ……..

Date of birth: ……....

Signature: …….

Date: …….