OSTEOBALANCE

# Patient Medical History Form

## Personal/contact information:

First name:

Last name:

Date of birth:

Address:

Suburb: Postcode:

Emergency Contact:

Mobile No.

Email address:

Occupation:

No. of kids:

Are you pregnant? ☐ Yes ☐ No Due date:

Sports/Hobbies:

## The reason for your visit today

What brings you here to see us today?

## GP Details: *(please complete)

GP Name: Practice Name:

☐ *I consent to my practitioner contacting my GP or other relevant treating health professional.

## How did you find us (please tick)?

☐ I was referred by my GP, Physio or another health professional.

↳ Please complete the details on reverse.

☐ I was referred by a family member, friend or workmate.

↳ Who? We'd love to thank them>

☐ I did a search on Google/ Bing/ Yahoo etc

☐ I found your flyer in my letter box

☐ AdWords – top of google search

## Do you have or have you had any of the following (please tick)?

☐ Bone fracture
☐ Joint dislocation
☐ Ligament tear
☐ Tendon tear
☐ Osteoporosis
☐ Osteoarthritis
☐ Diabetes

☐ Rheumatoid arthritis
☐ High blood pressure
☐ Low blood pressure
☐ Difficulty breathing
☐ Bleeding disorders
☐ Abnormal energy levels
☐ Heart failure
☐ Blood clots

☐ Sleeping problems
☐ Abnormal emotions
☐ Gynaecological concerns
☐ HIV/ Aids or other STD's
☐ Hot, Cold and Fever, Chills
☐ Allergies
☐ Cancer/family history of?

☐ Infection of the soft tissues or veins
☐ Deep Vein Thrombosis (DVT)
☐ Abnormal sweating/ night sweats
☐ Abnormal urine (odour, frequency, colour)
☐ Abnormal stools (loose/constipation)
☐ Abnormal thirst, appetite or taste

Many of our services are 'hands on'. Do you have any skin infections, bruising, wounds, eczema or any sensitive areas that your therapist/practitioner should be aware of? ☐ Yes ☐ No

Please list any **medications** you take, and why you take them:

.....

.....

Please list **surgeries** you have had, and when you had them:

.....

.....

## Consent for treatment:

Signing below informs us that you have read and understood our **'adverse reactions statement'**, our **'cancellation policy'**, our **'late arrival policy'** (all found on the reverse side of this document), that the medical information you have provide us is accurate and completed to the best of your knowledge, and that you consent to receiving treatment.

Signed (by a parent/guardian if under 16): x _____ Today's date: _____

**Adverse reactions statement:**

Our services have been found to be safe, simple, efficient and effective in the treatment of many conditions. On occasion however some patients do experience adverse reactions and we'd like you to be aware of these:

• Occasionally some patients experience muscle and joint soreness or the flair up of symptoms for several hours up to a few days following the first few treatments. This occurs whenever the function of a muscle has changed in response to a treatment - like when your muscles are sore after going to the gym for the first time in a long time. To minimise this please follow any advice your therapist/practitioner gives you. The advice given will be specific to you and your condition, and may include remaining active, undertaking specific exercises, being less active for a period of time, or dietary advice such as increasing your water intake or taking a particular supplement.

• In very rare instances (less than 1 in a million), patients who have had a pre-existing bone weakening disorder (for example, osteoporosis), or arterial disorder (for example, an aneurism), have experienced bone fractures, strokes and stroke like episodes following an upper cervical (neck) manipulation/adjustment. We have never had this occur at Osteobalance.

While your therapist uses the preceding questions as a 'screen' to help identify those at risk of experiencing adverse reactions, and adjusts their treatment accordingly, no questionnaire or clinical test can identify with 100% accuracy all conditions that may result in an adverse reaction. As such, neither your therapist/practitioner, nor King Dea Pty Ltd (trading as Osteobalance), nor its directors, will be held liable for the onset of adverse reactions brought on by the existence of a pre-existing condition.

If you do experience unexpected adverse reactions feel free to contact the clinic and ask for a 'call back' from your therapist/practitioner.

**Cancelation policy:**

If you cannot attend your appointment for any reason, please call us ASAP to reschedule. A late cancellation is one which occurs within 24 hours of your appointment, in which case the full consult fee is expected to be covered.

**Late arrival policy:**

Call us if you think you'll run late for your appointment- it's just polite to do so. Often, we are able to shuffle a few appointments around to accommodate you at a slightly later time. If you are late to an appointment we may have to adjust the duration of your appointment to ensure that other clients are not inconvenienced. If you are more than 15 minutes late, the cancellation policy will be applied

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**Details of Referring Health Professional**

Name:

Profession:

Practice Name:

Practice Address:

Phone Number: