

Forres Chiropractic Clinic

65 High Street, Forres, Moray IV36 1PB

Proprietor: Dr. David Morgan M.Sc., D.C. (Doctor of Chiropractic)

Member of the Scottish Chiropractic Association & Royal College of Chiropractors. Registered with the General Chiropractic Council

CONFIDENTIAL PATIENT RECORDS

Thank you for choosing Forres Chiropractic Clinic. All the information provided in these forms will be kept private and confidential while remaining in the trust and property of this clinic. Please fill out the following details in **CAPITALS**:

Personal Details

First Name(s): _____ **Surname:** _____

Title: Mr / Mrs / Miss / Ms / Other _____ **Date of Birth:** _____ **Age:** _____

Address: _____

_____ **Post code:** _____

Telephone (Home): _____ **Marital status:** _____

(Work): _____ (Mobile): _____

No. of children: _____ **Hobbies:** _____

E-mail: _____

Occupational History:

Do we have permission to contact your GP or Consultant (if necessary)? **YES** **NO**

How were you referred to Forres Chiropractic Clinic:

- Website Word of Mouth Advert in Press Passing by GP
 Screening Phone Directory Family/friend Other:

Are your fees covered by Insurance? yes no Insurer: _____

PLEASE NOTE WE DO NOT CURRENTLY ACCEPT REFERRALS FROM BUPA HEALTHCARE

General Health Information

GP Name: _____ **GP Tel:** _____

Address: _____

Date of last GP visit: _____ **Reason for visit:** _____

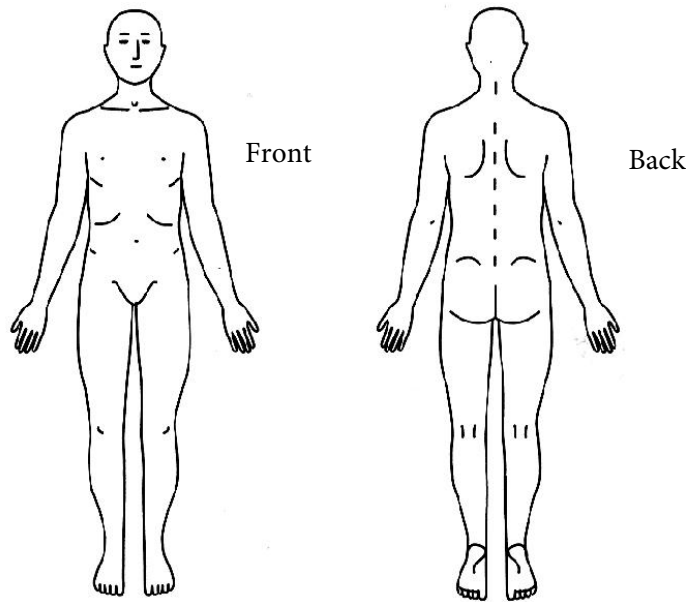
Do you/have you had any major health problems or operations: **YES** **NO**

Please list any **Medical Conditions** & approximate **date(s)** of Diagnosis & Treatment(s) :

List any **Medications** or Supplements that you take or receive regularly (or have recently stopped):

Area of Health Complaint(s)

Please mark the location(s) of your symptoms (pain, numbness, tingling)



On this Pain Scale from 0 – 10 please grade your pain by circling the appropriate box:

Least	0	1	2	3	4	5	6	7	8	9	10	Most
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Please tick box (if you currently or have previously suffered from any of the following):

Diagnosis /Symptoms	Yes	No	Diagnosis/Symptoms	Yes	No
Cancer (past/present)			Headaches		
Heart condition			Blurred vision		
High blood pressure			Dizziness		
Stroke			Sinus problems		
Blackout/faints			Ringling in ears		
Chest pain			Abdominal pain		
Chronic cough / Asthma			Trouble urinating		
Arthritis			Prostate problems		
Diabetes Type 1 or 2			Menstrual problems		
Thyroid problems			Allergies		

Other:

Have you ever broken any bones? **Yes No** History of Brittle Bones? **Yes No**
 Regular Steroid Use? **Yes No** Have you ever been in a road traffic accident? **Yes No**
 Have you had any x-rays or scans of the current area of pain? **Yes No**

Health care providers are required to advise patients of the nature of the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note:

- Whilst rare, rib fractures or muscle & ligament sprains/strains following an osseous adjustment have been reported;
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment. Less than 1 in every 3.7 million manipulations (J Manipulative Physiol Ther 2004 (Mar); 27 (3): 197-210);
- The risk of injury to a vertebral artery linked with spinal manipulation is **1 in every 4 million**. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. (Terrett AG. Vascular accidents from cervical spine manipulation: Report of 107 cases. J Aust Chiro Assoc 1987; 17: 15-24).
- Osseous and soft tissue manipulation have been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be a highly effective and safe treatment of spinal conditions including general pain, loss of mobility, headaches and other related symptoms.
- Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I give my informed consent to a Chiropractic Consultation, Physical Examination and, if appropriate, Treatment. I understand that a patient gown will be offered to me for modesty. I am aware of the potential risks as well as benefits associated with treatment, as well as alternative care such as medical referral. I accept that my records are to be legally held in the trust of this clinic. I understand that my GP or third party will only be contacted if I have given my consent previously on this form. I understand that 24 hours (or reasonable) notice must be given to change or cancel an appointment. Missed appointments or late cancellations may incur a half-fee charge at the clinic's discretion.

Signature:..... Dated:.....