CONFIDENTIAL PATIENT INFORMATION

Welcome to SpineCentral

Thank you for choosing SpineCentral to support your journey back to health. We are honoured to partner with you and are excited to begin this transformative process together.

At SpineCentral, we operate as an application-only practice. This ensures that we are the right fit for you and that we can fully meet your needs and expectations.

How We Work

Our approach at SpineCentral is unique and detailed—likely unlike anything you've experienced before. Your first two appointments will last approximately one hour each. Here's an overview of what to expect:

Your Practitioners

- All practitioners at SpineCentral are fully certified in Advanced Biostructural Correction (ABC), a specialised method distinct from traditional chiropractic care. ABC is practised by professionals across various health disciplines.
- At SpineCentral, our practitioners come from a range of professional backgrounds, including Chiropractors, Osteomyologists, and Sports Therapists.
- If you have a preference for working with a particular type of practitioner, such as a chiropractor, please let our reception team know or indicate this in the comments section.

Your First Visit

Your initial consultation will involve a thorough assessment by your Structural Correction Practitioner. This may include evaluations of your spine, posture, muscle function, neurology, and lifestyle factors.

- Typically, treatment is not provided on this visit unless you are in severe pain and no further investigation (e.g., X-rays) is required.

Your Second Visit

During your second visit, you will receive a Report of Findings detailing:

- What we have discovered about your case
- What steps can be taken to help
- The expected timeframe for healing
- The associated costs

Please confirm the following before proceeding:

- ☐ I understand that unless I am in severe pain, treatment will begin at my second session following a full assessment.
- ☐ I wish to address the underlying causes of my health and/or spinal issues, not just short-term symptom relief.
- ☐ I understand that SpineCentral specialises in the Advanced BioStructural Correction™ (ABC) method, which is a distinct technique and not classified as chiropractic.
- ☐ I understand that ABC practitioners at SpineCentral come from various professional backgrounds, including Chiropractic, Osteomyology, and Sports Therapy, and that all practitioners use the same ABC method of care.
- ☐ I understand that if I wish to see a specific type of practitioner, I can request this when booking with reception.

Name	Signature	Date

Personal History

Name: Date:

Date of birth (DD/MM/YY): Age :

Address: Postcode:

Email: Occupation:

Mobile number: Are you: ☐ Married ☐ Single ☐ Partner ☐ Widowed

Work Number: Spouse's/Partner's name:

Best time of day to contact you: Do you have children? ☐ Yes ○ No

If yes, what are their ages:

Do you have insurance that covers your care: ☐ Yes ○ No Name of Insurance Company:

Who may we thank for referring you?

Other doctors/practitioners you have seen for this condition:

Current Health

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	How long have you had it?	Have you had this condition before? If so when?	Did the problem begin with an injury?	% of the time the symptoms are present

Is your chief complaint: ☐ About the same ☐ Getting better ☐ Getting worse

What aggravates the condition: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Sleeping ☐ Lifting ☐ Other

What relieves the condition: ☐ Painkillers ☐ Rest ☐ Exercise ☐ Massage ☐ Ice ☐ Heat ☐ Stretching ☐ Other

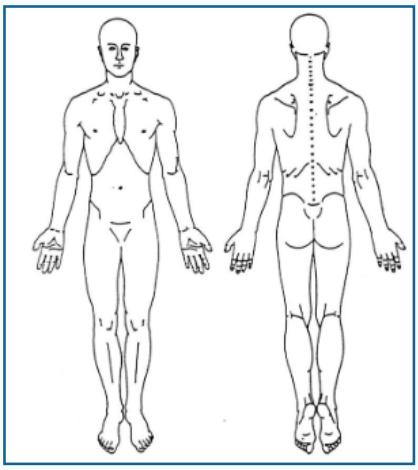
What type of pain are you feeling? Is your pain tender, dull, burning, deep aching, sharp, shooting, electric shock, toothache, band-like, tension/pressure, prickly, throbbing, boring, knife-like, other. Circle those applicable. Does it radiate anywhere? If so, where?

I do (do not) have a family history of this or similar symptoms (Please explain):

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

How does it affect you?	
☐ Restricts daily activities	☐ Hinders sports/hobbies
☐ Moody / Irritable	☐ Worry about future health
☐ Restrict household duties	☐ Interferes with job
☐ Distracted by symptoms	☐ Exhausted by the end of the day
☐ Hinders sleep	☐ Other

Please mark this diagram where you are feeling the symptoms.
Use an X for pain, N for numbness and P for pins and needles



Current GP and/or Primary Health Care Provider: Details:

Name:

Address:

General Health History

Check those questions to which you answer yes (even if they don't seem relevant to your current issue.
Leave the others blank) & comment below. Have you ever had or do you have any of the following health problems?
(- have had, + have now, leave blank if never had)

- ☐ Blood disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ ADD/ADHD
- ☐ Brain Fog
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep issues
- ☐ Frequent illness
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Eating disorder
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Cardiac disease or other problems
- ☐ Heart murmur or palpitations
- ☐ Heart attack
- ☐ Stroke or TIA
- ☐ High blood pressure
- ☐ Disease of the arteries
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Dental disease
- ☐ Neurological disease
- ☐ Seizure disorder
- ☐ Gastrointestinal disease
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder disease
- ☐ Gastritis/Ulcer disease
- ☐ Acid reflux
- ☐ Haemorrhoids
- ☐ Kidney infections/disease
- ☐ Kidney stones
- ☐ Bladder infection
- ☐ Thyroid disorder or other hormonal disorder
- ☐ Varicose veins
- ☐ Lung Problems
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Seasonal allergies
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Blood clots, DVT or Embolism
- ☐ Substance Abuse (Alcohol, other drugs)
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Osteoporosis or osteopenia
- ☐ History of fractures
- ☐ Alcoholism
- ☐ History of significant trauma
- ☐ Inflammatory arthritis (Rheumatoid etc)
- ☐ Developmental anomalies of the spine
- ☐ Headache/migraine
- ☐ Dizziness
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Middle back pain
- ☐ Lower back pain
- ☐ Hip, Knee, Ankle
- ☐ Shoulder, Elbow, Wrist
- ☐ Disc injury
- ☐ Sciatica

Comments:

If you are currently experiencing spinal, neck, back or arm/leg pain do you?	Yes	No
Hurt to cough/sneeze/pass a stool	☐	○
Hurt to bend down (put on socks and shoes etc)	☐	○
Have pain radiating below your knee	☐	○
Pins and Needles or numbness in the leg or foot	☐	○
Have weakness of foot/leg	☐	○
Difficulty walking normally	☐	○
Do either of your legs suddenly give way	☐	○
Are you tripping up and scuffing your foot whilst walking	☐	○
Difficulty getting out of a chair or up/down stairs	☐	○

The following questions may seem unusual but please answer yes or no to each one:	Yes	No
Do you have:		
Severe pain waking you up at night (regardless of which position you lie in)	◯	◯
Were your current symptoms preceded by a fall or other traumatic incident?	◯	◯
Have you taken oral corticosteroid medication either now or in the past?	◯	◯
Are you experiencing a loss of your normal appetite?	☐	◯
Are you experiencing abnormal amounts of fatigue?	☐	◯
Unexplained weight loss (losing more weight than you would normally expect to lose?)	☐	◯
Changes to bowel and bladder habits (frequency, urgency, incontinence, constipation)	☐	◯
Difficulty starting or stopping your urine flow	☐	◯
Loss of feeling/pins and needles between your inner thighs or genitals	☐	◯
Numbness in or around your back passage or buttocks	☐	◯
Altered feeling when using toilet paper to wipe yourself	☐	◯
Increased difficulty when you try to urinate	☐	◯
Increased difficulty when you try to stop or control your flow of urine	☐	◯
Loss of sensation when you pass urine	☐	◯
Not knowing when your bladder is either full or empty	☐	◯
Loss of sensation when you pass a bowel motion	☐	◯
Loss of sensation or function of your genitals during sexual intercourse	☐	◯
Do you have to get up more than once in the night to urinate (men)	☐	◯
Severe headache never experienced before?	☐	◯
A history of cancer (even if it was many years ago)	☐	◯
Osteoporosis or osteopenia	☐	◯
Have you experienced a recent infection or illness within the last 3 weeks?	☐	◯
Females - Have you been through the menopause or are you currently going through it?	☐	◯
Are you on hormone replacement therapy?	☐	◯

MEDICATIONS	SURGERIES	DIAGNOSTIC IMAGING
List any prescription medications (with dosage and frequency of use) you are now taking:	Type of surgery and specific date or your age at surgery, include any joint surgeries, arthroscopies or steroid injections:	Have you had any X-Rays, MRI or CT scans taken in the past 5 years?
List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use)	**DENTAL HISTORY**	**ALLERGIES**
	Type of dental surgery and procedures in the past (teeth extraction, crowns, implants, root canal, orthodontics, TMJ splinting, bridges etc.):	List any drug or medical materials (latex) allergies and reaction:

Family History

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave others blank).

☐ Heart attacks under age 50	☐ Diabetes	☐ Cancer
☐ Strokes under age 50	☐ Arthritis	☐ Neurological disorders
☐ High blood pressure	☐ Heart operations	
☐ Elevated cholesterol	☐ Autoimmune conditions	

Health and Lifestyle

PHYSICAL STRESS HISTORY

Do you sit for more than 3 hours per day on average?	○ Yes ☐ No

Heavy falls, Sports accidents, injuries, sprains, strains, fractures, dislocations or concussions. Please list your accident history

Have you been involved in a car crash or experienced a whiplash injury? Yes No. Please give brief details:

Do you know if you experienced a traumatic birth process? (Ventouse, breech, emergency c-section or forceps?)

Did you in the past or do you currently play a contact sport? (Rugby, football, martial arts, boxing etc)

Do you regularly exercise? If so how many hours per week and what do you primarily do?

What mattress do you sleep on (check those applicable)? ☑	☐ Memory foam ☐ Pocket sprung ☐ Firm ☐ Medium ☐ Soft
What position do you sleep in (check those applicable)? ☑	☐ Front ☐ Back ☐ Side
Do you wear orthotics or arch supports?	○ Yes ○ No
Do you do regular yoga, stretching, pilates?	○ Yes ○ No
Do you do foam rolling on your spine?	○ Yes ○ No
Do you get regular massages?	○ Yes ○ No
Do you wear posture support braces or straps?	○ Yes ○ No

CHEMICAL STRESS HISTORY

Do you smoke?	○ Yes ○ No
If you smoke, how many per day?	Age started
Do you drink alcohol regularly?	○ Yes ○ No
If you drink, how may drinks per week?	Age started
Have you ever felt you should cut down on your drinking?	○ Yes ○ No

Do you follow any special diets? Please specify

How would you rate yourself in terms of maintaining a healthy diet on a scale of 1-10 (1 being terrible, 10 being perfect)

EMOTIONAL STRESS HISTORY

How would you grade your emotional health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting worse

Do you regularly practice some form of stress reduction habit? ○ Yes ○ No (check those which apply)

☐ Meditation Journalling ☐ Prayer Thai Chi

Would you like us to inform your General Practitioner (GP) about your visits to Spinecentral?

Is there anything else you would like to add or discuss with your practitioner?

What would you love to be able to do again in your life? (that you cannot do now because of this pain?)

On a scale of 1-10 how committed are you to solving this health challenge and regaining your physical health?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Consent To Examination

The statements made on this form are accurate to the best of my recollection. I consent to a complete professional neuromusculoskeletal examination, including nerve scans and posture pictures. I consent to a clinic assistant completing part of this examination process (the taking of posture pictures and nerve scans) and understand that they are fully trained in the operation of the technology and that the pictures and all of my case notes are confidential and stored on a secure database. No third parties have access to our records. The practitioner alone makes all clinical decisions and diagnoses after completing a thorough structural, postural, orthopaedic and neurological examination. Treatment will commence once all of this information has been duly considered on a case by case basis.

The clinic operates on a 'payment at time of examination and treatment' policy. The fees are displayed at reception but should you have any queries please speak to a member of our team. 24 hours' notice is required for cancellation or you will be charged a cancellation fee for the visit. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. We may periodically contact you with details of complimentary products or services.

Signature: **Date:**

If under 16:

Guardian's signature: **Date:**

Consent to Treatment

Please read this consent form, discuss it with your practitioner if you would like to and then sign where indicated at the bottom.

Chiropractors/Osteomyologists/ABC™ Practitioners/and other health professionals who use manipulation techniques, such as for example joint adjustment or manipulation or mobilisation, are required to inform patients that there are or may be some risks associated with such treatment. In particular;

a. While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manipulation therapy.

b. There are reported cases of stroke associated with visits to medical doctors and practitioners using joint manipulation as a treatment. Research and scientific evidence does not establish a cause and effect relationship between manipulative treatment and the occurrence if stroke; rather, recent studies indicate that patients may be consulting medical doctors, chiropractors, osteopaths, sports therapists, physiotherapists, osteomyologists or ABC™ practitioners when they are in the early stages of stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association, because stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

c. There have been reported cases of disc injuries following spinal manipulative therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment and/or mobilisation have been the subject of much research over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided and this clinic may also contribute to your overall wellbeing. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments from the same forms of musculoskeletal pain and other associated syndromes.

Your practitioner will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral from consultation and/or further if deemed necessary.

Acknowledgment: I acknowledge I have discussed, or have been given the opportunity to discuss, with my practitioner the nature of manipulative ABC treatment and my treatment in particular as well as the contents of this consent.

COVID-19

Our patients' health and wellbeing are our number one priority. Even though the risk from COVID19 has reduced, we are continuing to take extra precautions to maintain a healthy and safe environment for healing. These include, but are not limited to, sanitizing frequently touched objects such as adjusting tables and equipment after each patient, door handles, credit card machines and light switches. We are also regularly washing and sanitizing our hands. We are rigorously following the guidelines laid out by the Government, our Statutory Regulator, our governing bodies and professional associations. We wish to keep our team and our community of patients safe during this time.

Acknowledgement:

I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of ABCTM joint manipulation treatment and my treatment in particular, as well as the contents of this consent. I acknowledge that I have had the opportunity to ask all the questions I wish to at this time.

Consent to Treatment

Consent:

- I understand that there is a risk of transmission of COVID-19 (coronavirus) as a result of attending (insert clinic name) and/or receiving an examination, x-rays, or treatment
- I understand that every reasonable precaution has been taken by Spinecentral Ltd to limit my exposure to COVID-19.
- I consent to the examination, x-rays or treatment(s) offered or recommended to me by my practitioner, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs, and lower limbs), as well as the meningeal releases (deep spinal stretches) that are part of the ABCTM method. I intend this consent to apply to all my present and future treatments at this clinic.

Comments:

Date

Patient Signature

Name:

(Please print name of patient)

Name:

(Please print name of Witness/Translator)

Signature of Guardian
(where applicable)

Name:

(Please print name of guardian)

Name:

(Signature of Witness/Translator)

Your Journey Toward Regaining Physical Health

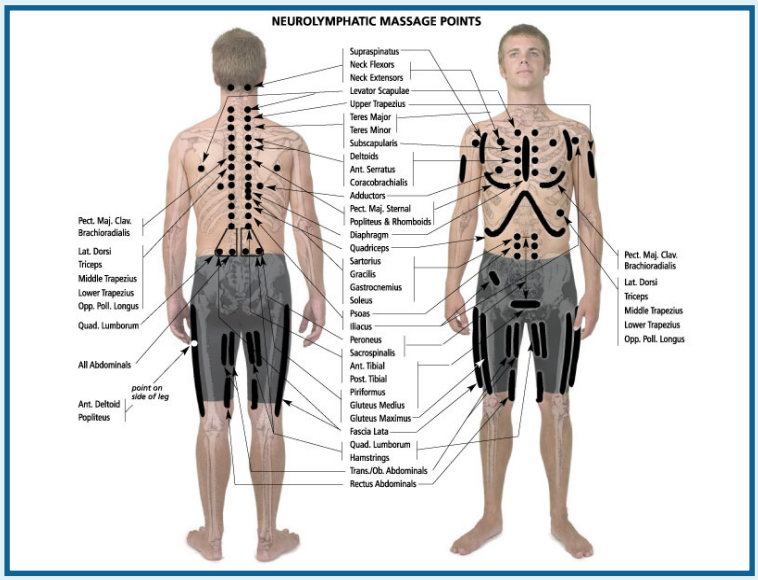
At SpineCentral, we use **Advanced BioStructural Correction™ (ABC™)**, a specialised technique that reduces tension and realigns the structures your body cannot correct on its own.

We typically observe improvements in body structure, function, and posture both immediately and more deeply over time. **Your results, however, depend entirely on your commitment to following your practitioner's advice.**

During this journey, your body will follow a path of progression known as **'Unwinding,'** which involves periods of both **'Forward (Stable) Phases' and 'Backward (Unstable) Phases'** as previously explained to you.

It is important to keep your practitioner informed of any changes you observe, particularly if you are worried or have questions.

Some of your treatment at SpineCentral may involve the use of reflex/massage techniques, which require light pressure to specific points on the body, some of which may be near 'sensitive/private' areas. This will always be explained in advance and performed with the utmost care.



Commitment to Your Results

In addition to regular visits to our clinic, your progress requires changes to key habits at home. These habits involve: • How you **sit** • How you **sleep** • How you **stand**

To help with these changes, we provide an ABC Essentials Kit, a carefully designed resource to ensure your daily habits support, rather than hinder, your recovery. Your practitioner will explain these changes in detail, including how to use the kit effectively.

The two-step protocol of clinic care and at-home lifestyle modifications are inseparable. Compliance with both is essential to achieve the best possible results.

By Signing Below, You Agree to the Following Statements:

- I understand everything explained to me, including the Unwinding Process and the advantages and disadvantages of care.
- I will observe changes in my body and report them to my practitioner.
- I will comply with the advice provided, including attending appointments regularly and using the ABC Essentials Kit to make the necessary changes at home to improve my sitting, sleeping, and standing habits.
- I will inform my practitioner if I change my mind about our agreed Schedule of Care.
- During the Forward Phase, I will prioritise getting checked as soon as possible and understand that I may need additional adjustments that week.
- I understand that during structural correction, there may be times when I don't feel good, and I recognise this as part of the natural healing process.
- I understand that my practitioner may need to address reflex points located on my body, which may occasionally be tender or near sensitive areas, and I agree to these techniques as part of my care.
- I acknowledge that the intentions of SpineCentral practitioners are solely to improve my health using these techniques and that they are in no way inappropriate.
- I understand that I can choose to opt out of treatment at any time by making a simple request to stop.

Patients Signature

Date:

WAIVER CONSENT FORM

I give my permission to be examined by the practitioner for the purposes of assessment and diagnosis.

If, after examination and diagnosis, the practitioner considers it necessary to provide manipulative adjustments or other treatment,

And these have been explained to me,

I consent to proceed with the agreed treatment plan.

I also agree to pay the relevant fee for any treatment received.

I confirm that I have read and understood the "NOTICE TO PATIENTS" below

NOTICE TO PATIENTS

THE PRACTITIONER YOU ARE CONSULTING **(Mr. Laurence Williams-Thomas, MAO)**

IS A LEVEL 2 CERTIFIED ADVANCED BIOSTRUCTURAL CORRECTION™ (ABC) PRACTITIONER.

HOLDS FULL PROFESSIONAL INDEMNITY INSURANCE COVER.

IS ENTITLED TO PRACTISE AS A REGISTERED OSTEOMYOLOGIST USING THE ABC™ METHOD.

IS A QUALIFIED SPORTS THERAPIST.

IS NOT A CHIROPRACTOR.

Patients Signature

PRINT NAME

Date: