CONFIDENTIAL PATIENT INFORMATION

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?

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

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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?

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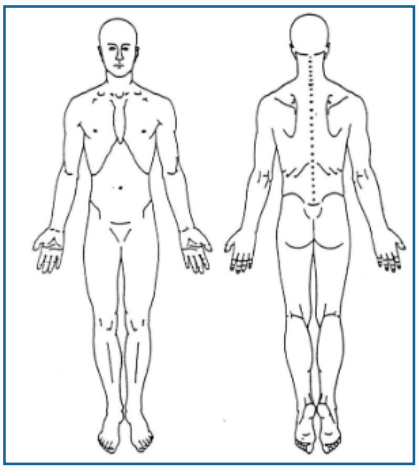
How does it affect you?	
☐ Restricts daily activities	☐ Hinders sports/hobbies
☐ Moody / Irritable	☐ Worry about future health
☐ Restrict household duties	☐ Interferes with job
☐ Distracted by symptoms	☐ Exhausted by the end of the day
☐ Hinders sleep	☐ Other

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

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 (circle those which apply) Meditation Journalling, Prayer Thai Chi

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

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

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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/ABCTM 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 and chiropractors, osteopaths 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.

Consent: I consent to the treatment(s) offered or recommended to me by my practitioner, including joint adjustment or manipulation or mobilisation of the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Patients Signature .....

Name (please print) .....

Date: .....

If under 16:

Parent's/Guardian's signature .....

Parent's/Guardian's Name (please print) .....

Date: .....

Your Journey of Health

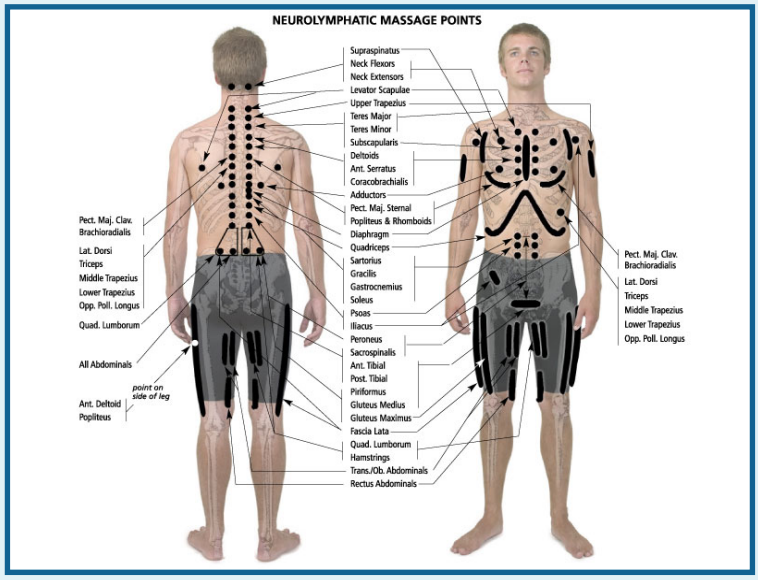
Excessive tension has been found in your spine; nervous system, plus bones & joints which are not optimally aligned. This affects your overall health.

Advanced BioStructural Correction™ (ABC™) is a technique which specifically reduces tension and realigns the structures that the body cannot correct itself.

We normally see body structure, function & posture improve immediately & more deeply over time. Results completely depend on compliance to your practitioners advice.

During this Journey, your body will follow a path of progression ('Unwinding') which includes 'Forward (Stable) Phases' and 'Backward (Unstable) Phases', as discussed.

It is important to keep your doctor informed of any changes that you observe, and especially if you are worried or do not understand something.



Some of these points are near to 'sensitive/private' areas of the body.

Please sign below if you agree with these statements & you are happy to start your

I agree that :

- I understand everything explained to me, including the Unwinding Process, and the advantages & disadvantages of care.
- I will observe changes in my body & let you know about them.
- I will comply with the advice to the best of my abilities.
- I will let you know if I change my mind about our agreed Schedule of Care.
- During the 'Forward Phase', I will do the upmost to get checked as soon as possible & may need extra adjustments that week.
- I understand that during structural correction there will be times when I don't feel good and understand that this is part of the natural healing process.
- I understand that as a part of my healing journey that my practitioner may need to treat various reflexes that are located on my body and that these reflex points may be tender to pressure and or on/close to 'sensitive' areas of my body.
- I understand that the SpineCentral Practitioners intentions are solely to improve my health condition by using these techniques and that they are in no way inappropriate.
- I understand that I have the power to opt out of treatment any time that I chose by making a simple request for treatment to stop.

Patients Signature .....

Date: .....