

Personal History and Consent Form

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| Given Name: | Surname: |
| Preferred Name: | Date of Birth: |
| Address: |
| Home Phone: | Work Phone: |
| Mobile Phone: | Email: |
| Occupation: | GP: |
| Emergency Contact (name and number): |
| Current Medications (prescription, vitamins, herbs, supplements): |
| Previous medications: |
| Medical History (Accidents/Illness/Hospitalisation/Pregnancies/Surgery): |
| What do you hope you gain from your visit to this practice? |
| Is there anything else you’d wish to share? |
| How did you hear about us? |

**INFORMED CONSENT**

I understand that, when performed by a qualified practitioner, soft tissue therapy, mobilisations, myofascial release, assisted stretching, spinal adjustments and breath awareness are effective, safe methods of treatment for many conditions. I also understand that there are some adverse responses and risk associated with treatment. I do not expect the practitioner to be able to anticipate every possible, adverse response and complication that may arise with treatment. I wish to rely on the practitioner to exercise judgement during the course of treatment. I intend this form to give my consent to release any relevant medical results to this practice including x-ray, CT and MRI reports and results.
Name: Date: