



# NEW PATIENT FORM

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

\_\_\_\_\_

Employer \_\_\_\_\_

State \_\_\_\_\_ Postcode \_\_\_\_\_

Email \_\_\_\_\_

Phone (M) \_\_\_\_\_

Referred by \_\_\_\_\_

(W) \_\_\_\_\_

(H) \_\_\_\_\_

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What is the main purpose of your visit today? \_\_\_\_\_

Have you been to an Osteopath previously?  yes  no

If so, what for? \_\_\_\_\_

Do you have any existing medical conditions? \_\_\_\_\_

List any injuries, accidents, operations; \_\_\_\_\_

List any medications or supplements you are currently taking; \_\_\_\_\_

Do you suffer or have suffered from any of the following?

High or low blood pressure  yes  no

Breathing difficulty  yes  no

Stroke  yes  no

Skin conditions  yes  no

Headaches, migraines  yes  no

Allergies  yes  no

Cancer  yes  no

Digestive problems  yes  no

Further details \_\_\_\_\_

Do you smoke?  yes  no

Are you pregnant?  yes  no

List your sports, exercise activities; \_\_\_\_\_

GP Name: \_\_\_\_\_ GP Phone: \_\_\_\_\_

GP Address/Suburb: \_\_\_\_\_

I consent to City Osteopathy notifying my GP that I am having Osteopathic Treatment. (PTO for consent form)

## Consent to Osteopathic Care

Osteopathic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks with all health care procedures, which you should be informed about. All practitioners who use Osteopathic Manipulative Treatments on a patient are required to warn patients of the possible risks associated with those procedures. In very rare circumstances, some treatments of the neck may damage blood vessels and even give rise to stroke like symptoms. *(It is believed the risk may be approx. 1-2 strokes per 1,000,000 neck manipulations performed).*

Please read the following carefully;

1. It has been explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I acknowledge that I have discussed with my Osteopath the rare risks associated with my treatment which include but are not limited to muscle and joint soreness or strains, nausea, dizziness, fractures, disc injuries, strokes ( or like episodes), dislocation, bleeding, bruising, inflammation and an exacerbation or aggravation of my underlying condition.
2. I have had the opportunity to discuss the proposed care with the osteopath (named below); I have disclosed all relevant health information. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care and other alternative treatments and been given sufficient time to make a decision giving consent for the care to proceed.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that a result cannot be guaranteed.
4. I do not expect the Osteopath to be able to anticipate every potential risk and complication associated with the proposed treatment/procedure.
5. I hereby acknowledge my consent to the performance of the proposed Osteopathic care by the osteopath below. I understand that I can withdraw consent at any time in writing and that this consent form does not encompass the entire discussion I had with the Osteopath regarding proposed treatment.

Patients name..... Patients Signature.....

Osteopaths name..... Osteopaths Signature.....

Dated.....