Hilton Chiropractic
Health Care for All the Family

PATIENT DETAILS

Title: (Mr, Mrs, Ms, Dr, Miss, Master,) _____ **DOB:** _____

First Name: _____ **Last Name:**_____

Address: _____

Mobile/Home number: _____ **Email:** _____

Occupation: _____ **Private Health/Which One?:**_____

Is this a worker's comp or insurance claim? _____

How did you hear about this clinic (If a person, name)? _____

Chief Complaint (what hurts most):_____

Emergency Contact: **Name:**_____ **Phone:** _____

Would you like to receive correspondence from us via email?_____

SPECIAL PATIENT INFORMATION

The law now requires that all practitioners who manipulate the spine to inform patients of the material risks of such treatments. In extremely rare circumstances, some treatments of the neck may cause damage to a blood vessel and give rise to a stroke or stroke like symptoms (approximately 1 in 5.85 million neck manipulations (Haldeman et al., Spine vol24-8, 1999). While this has never occurred in this clinic, we are still required to inform you. If any adjustments (manipulations) are required you will be tested before hand, as has always been our practice. Other very slight risks include strain/injury to a ligament or disc in the neck (1 in 139,000) or low back (1 in 62,000). (Dvorak study in Principles and Practice of Chiropractic, Haldeman 2nd Ed)

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives (Risk Assessment of Cervical Manipulation, JMPT, 1995, Manga Report, Ontario Ministry of Health, 1993).

As part of our clinic's Terms of Engagement please be aware that we require 4 hours notice when rescheduling or cancelling an appointment. We reserve the right to charge a $25 missed appointment fee if we do not receive this notice.

If you have any questions related to the treatment you are about to receive, please feel free to speak to the chiropractor.

I _____, have read, and understand the above information, and I am aware that I may ask questions at any time regarding the proposed treatment. I hereby give consent for treatment.

Patient/Parent/Guardian's Signature: _____ ***Date:*** _____

Chiropractor's Signature: _____ ***Date:*** _____