Practitioner :		Date of First Visit:	

Title:	Mr/Mrs/Ms/Miss				
First Name:		Last Name:			
Address:					
		Post Code:			
Date of Birth:		Age :	Male ☐	Female ☐	
Marital Status :		No of children :		No of Grandchildren:	
Mobile		Telephone:			
Email:					
Occupation :		Company :			
How did you hear about us?	Advertising ☐ Internet/Website ☐ Walk-in ☐ Other ☐ Referral ☐ (name of referee):				
Weight (KG)		Height (METRES)			

All the above information is correct and I hereby give my consent to undergo a full examination by the practitioner.

I consent to Spirohealth using my information for the purposes of optimising my health care.
Spirohealth do not share information for the purposes of marketing.

Patient signature: ____ Date: ___________________________

Please read this Important information:

- Please ensure you are on time for all your appointments, 5 minutes late affects the Doctors schedule and they may not be able to see you as a result. If you are running late, please contact the practice as soon as possible on 0208 780 5656 so we can try to accommodate you.
- Cancellations are to be done 24 hours before appointment; failure to do so may result in you being charged for the appointment.
- An Initial Consultation is approx. 30-45 minutes long, so please allow for this
- Once the initial consultation has been done, the next appointment will be a Report of Findings, where you find out exactly what is wrong with you, how we can help you, how many sessions it will take and the cost involved, this appointment is approximately 30-45 minutes, so please allow for this too.
- Please note every 12th appointment by law a re-exam will be done, this is to update you on your progress thus far and to answer any questions you might have, a photo will also be taken so please ensure you keep your shoes removed and come straight upstairs once you have finished your appointment with the doctor.
- Pictures are taken every 6th appointment to help the doctors to track your progress.

I .... have read and understand the office procedures and cancellation policies
Signature: ____________________ Date: ____________________

Welcome, we look forward to helping you on your journey to get you BACK to your best

Changes to the law now require all chiropractors to warn people of material risks. Chiropractic care is recognized as being an effective and safe method of care for many conditions.

However, as in all health care, there are some very slight risks with chiropractic care. This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [(1)];
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments) [(2) (3)].

Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs [(4)] and safer than driving a car [(5)].

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding. [(6) (7)] this is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates ***unexpected improvement*** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health.[(8)] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14%: eyes/vision.

Broken down into subcategories the benefits were reported as follows

Easier to breathe: 21%,
Improved digestive function: 20%, Clearer/better/sharper vision: 11%,
Better circulation: 7%
Changes in heart rhythm/blood pressure: 5%, Less ringing in the ears/improved hearing: 4%**Agreement:**
(The references for the information quoted above are available upon request.)

Agreement:

I have read and understand the information above.

I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise his/her judgment during the course of procedures which he/she feels, at the time, based upon the facts known, is in my best interests.

I understand that the intent of Corrective Care is to enable my body to regain more structural balance and improved function. I understand that this is elective care that does not rely on the presence of symptoms for its application and monitoring. I understand that there is little evidence in the literature for this type of care.

I have, to the best of my knowledge, provided the chiropractor with a complete and accurate health history. I have read the above consent. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic, examinations, adjustments and other chiropractic procedures wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Signature: ______________________________ **Print name:** ______________________________
(Parent /guardian if under 18 years)
Child's name: ______________________________

Chiropractor's signature: ______________________________ **Date:** __________________

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8);530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9);42-47.Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15;22(4):435-40; disc'n 440-1.
(6) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999;22:559-64.
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15;22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999;22:559-64.

Your Journey of Life

During the course of your life's journey you may have encountered many stressors. Whilst some of these stressors may have seemed small, they may have had an accumulating effect on your life, Please answer the questions on the following issues that commonly arise through the formative years;

Pre-Pregnancy

Did your Mum & Dad...

	YES	NO	UNSURE
Plan and welcome the pregnancy?	☐	☐	☐
Prepare their bodies for pregnancy	☐	☐	☐

Pregnancy

Did your Mum...

	YES	NO	UNSURE
Have chiropractic care during pregnancy	☐	☐	☐
Exercise through pregnancy	☐	☐	☐
Have a nutritious diet during pregnancy	☐	☐	☐
Get injured during pregnancy	☐	☐	☐
Smoke or drink alcohol during pregnancy	☐	☐	☐
Endure stress during pregnancy	☐	☐	☐

Birth Process

Your birth ....

	YES	NO	UNSURE
Home Birth	☐	☐	☐
Hospital birth	☐	☐	☐
Was your birth early/late(according to due date)	☐	☐	☐
Induced labour	☐	☐	☐
Drugs during delivery	☐	☐	☐
Was the delivery long?	☐	☐	☐
Was the delivery difficult?	☐	☐	☐
Caesarean (Elective/Emergency)	☐	☐	☐
Presentation position:	☐	☐	☐

Posterior, breech, correct, transverse, other ______________________

Growth and Development

Physical	YES	NO	UNSURE
Physical abuse by siblings/others	☐	☐	☐
Violently pulled by the arm	☐	☐	☐
Were you a head-banger?	☐	☐	☐
Did you fall on your head?	☐	☐	☐
Did you fall down stairs?	☐	☐	☐
Were you taught how to care for your spine?	☐	☐	☐
Did you have the chair pulled from under you?	☐	☐	☐

Chemical

Were you breast fed? If so for how long? ______________________

Were you bottle-fed? If so for how long? ______________________

Mental/Emotional

Was there communication breakdown in your household?	☐	☐	☐
Was there a loss of a close relative?	☐	☐	☐
Was there any stress in the family?	☐	☐	☐

Lifestyle

	YES	NO	UNSURE
Do you smoke?	☐	☐	☐
Do you drink alcohol?	☐	☐	☐
Do you drink adequate water	☐	☐	☐
Do you eat healthy foods?	☐	☐	☐
Are your teeth healthy?	☐	☐	☐
Do you sleep well?	☐	☐	☐
Do you exercise regularly?	☐	☐	☐
Are you physically stressed?	☐	☐	☐
Are you mentally stressed?	☐	☐	☐

Are you being, or have you been, exposed to chemicals? ____________________________

Are you taking, or have you ever taken, drugs? ______________________

Sports: ______________________

Hobbies: ______________________

Accidents: ______________________

Surgery: ______________________

Have you experienced a loss in the past 5 years? (e.g. relationship, family, business, financial)

____

Health Objectives

People consult this office with one or more of the following health objectives. Please indicate which apply to you,

- ☐ Relief of my symptoms.
- ☐ Correction of my underlying problems.
- ☐ To maximise my health.
- ☐ Maximise myself my family's and community health.

You may have specific reasons for consulting this office. If this is the case what are they?

____

How would you rate your overall health? _/ 10

What would you like your health to be? _/ l0