OSTEOPATHY
NEW PATIENT REGISTRATION FORM

Full Name: _____

Date of Birth: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

(For the purpose of practitioner communication and promotion of services)

Postal Address: _____

Town: _____ Post Code: _____

Occupation: _____

Regular GP: _____

Do you have Private Health Insurance with Extras cover? Yes No

HEALTH HISTORY

What are the two main reasons for your visit today? _____

_____

List any injuries, accidents, operations: _____

_____

List any medications or supplements you are currently taking:_____

_____

Please mark below any conditions that apply (and if necessary, briefly explain):

High/Low Blood Pressure	☐	Headaches/Migraines	☐	Stroke	☐
Heart attack/Chest pain	☐	Osteoporosis/Osteopenia	☐	Cancer	☐
Dizziness/Fainting	☐	Asthma/Breathing Difficulties	☐	Pregnant	☐
Allergies/Food	☐	Arthritis	☐	Other	☐

Other Details: _____

Family history of any of the above: _____

The information in this form is used for direct patient contact, referral to other health professionals and YOUR BODY. YOUR HEALTH. practice development purposes only. After data has been entered into the practice management program, this form will be destroyed.

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 approximately 1-2 strokes per 1,000,000 neck manipulations performed*). Your osteopath is trained to screen patients for possible risks and adverse reactions.

Please read the following carefully;

1. There are certain inherent and potential risks in any treatment plan or procedure. I acknowledge that I can discuss with my Osteopath the rare risks associated with my treatment which include but are not limited to muscle and joint soreness/strains, nausea, dizziness, fractures, disc injuries, strokes (or stroke-like episodes), dislocation, bleeding, bruising, inflammation and an exacerbation or aggravation of my underlying condition.
2. I have the opportunity to discuss the proposed care with the Osteopath (named below); I will disclose all relevant health information. I also acknowledge that I have the opportunity to ask questions about the nature, extent and purpose of the proposed care and make a decision giving consent for the care to proceed.
3. I acknowledge that I am aware of and understand that there can be 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 plan/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 verbally or in writing and that this consent form does not encompass the entire discussion I had with the Osteopath regarding proposed treatment.

**** PLEASE NOTE: Your Body. Your Health. has a cancellation policy.**

We do understand that sometimes your appointment time may no longer suit, however we do appreciate as much notice as possible when ringing to cancel.
Where possible, please notify us within 24 hours of your appointment.
If you cancel within **4 hours of your appointment**, you risk a cancellation fee of **$30**.
If you **do not show** for your appointment, a full consultation fee of **$70** (initial consult) or\ **$65** (return consult) will be charged.
We hope you understand.

Patient Name: _____

Patient Signature: _____**Dated:** _____

Parent Name: _____ (If patient is under the age of 18 years)

Parent Signature: _____

Practitioner Signature: _____

CONSENT FOR DRY NEEDLING

Dry needling is a valuable adjunct treatment for chronic pain, stiffness, and to deactivate myofascial trigger points. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure.

With the dry needling technique, a fine, flexible and sterile needle is used. The purpose of the needling is to release shortened bands of muscle caused by abnormal functioning of the nervous system. No drugs are injected.

Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increased pain is related to overactive shortened muscle bands that have not been released and to the soreness caused by the “twitching” of the muscles.

Any time a needle is used there is a risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) will develop. If a nerve is touched, it may cause paresthesia (a prickling sensation) which is usually brief, but it may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility of a pneumothorax (air in the chest cavity).

Fortunately, all these complications are not fatal and are readily reversible.

Care will always be taken to respect your privacy; appropriate towelling will be used at all times.

I have read or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask any questions I had and all of my questions have been answered. I consent to dry needling at YOUR BODY. YOUR HEALTH.

Signature: _____ **Date:** _____

Print name: _____

Practitioner Signature: _____