Dr Julia Higgins
B. App. Sci (Clinical) B Chiropractic Sci.
P/N: 2240646X

Dr Jessica Mibus
B. App. Sci (Comp. Med-Chiro)
M Clinical Chiropractic
P/N: 4115426T

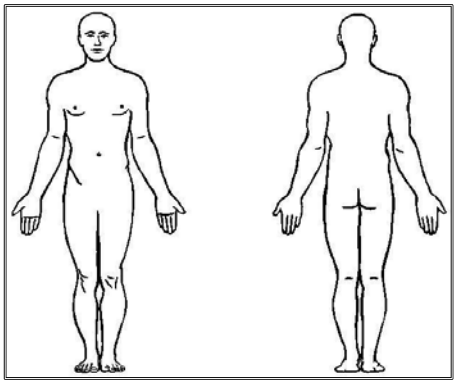
Bacchus Natural Health

91 Gisborne Rd
Bacchus Marsh, Vic, 3340
Ph: (03) 4302 9600 Fax: (03) 4302 9570
info@bacchusnaturalhealth.com
ABN: 90 785 028 879

Surname: _____ First name: _____
Address: _____
Postcode: _____ Date of birth: _____/____/_____
Home phone: _____ Mobile phone: _____
Occupation_____ Private Health Fund: _____
Emergency contact name & phone: _____
Have you previously seen a Chiropractor: Yes/No How long ago: _____
How did you hear about us? _____

PLEASE DRAW ON THE DIAGRAM →

- **For pain use XXX**
- **For tingles use ///**
- **For Numbness use 000**



If you have any medical conditions or taken any medications, please list them and describe what you take each one for:

_____
_____
_____

If you have had an x-rays or scans taken of your spine please list where and when they were taken.

_____
_____

Any history of cosmetic implants or pacemaker surgery?

_____
_____

***Please note that missed appointments with a minimum of 2 hours notice will be charged for.**

Signature: _____ Date: ____/____/_____

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CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. You must recognize, however, that there are risks associated with all health care procedures.
Please read carefully the following risks you should be informed about.

I acknowledge that I have discussed with Dr Julia Higgins, Dr Jessica Mibus or any other chiropractor working in this clinic the rare risks associated with my care, including but not limited to:

- Muscle and joint soreness or strains
- Nausea and dizziness
- Fractures
- Vascular injuries
- Disc injuries
- Strokes, or stroke-like episodes (risk: 1: 1,000,000 to 1: 10,000,000)
- Exacerbation and/or aggravation of my underlying condition

I acknowledge that I have had the opportunity to discuss my proposed chiropractic care, including the opportunity to ask questions about the nature, extent and purpose of the proposed treatment. I have been given sufficient time to make the decision of giving consent for the care to proceed. I acknowledge that I am aware of, and understand the potential risks and I appreciate that results are not guaranteed.
I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care, but I wish to rely on the doctor to exercise judgment during the course of my treatment and to act in my best interests at all times.
Should I for any reason require emergency medical attention (i.e. CPR or Ambulance attendance) I authorise the clinic to act on my behalf.
I hereby acknowledge my consent to the performance of the proposed chiropractic care. I understand that I can withdraw my consent at any time.

_____ _____

Patient's signature — Chiropractor's signature
(Parent or Guardian to also sign if patient under 18)

_____ _____

Patient's Name (printed) — Date

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MEDICAL RECORD RELEASE AUTHORITY

I intend for this form to give my consent to release any relevant medical results to this clinic, including X-Ray, C.T., M.R.I and blood test reports.

I understand that I can withdraw my consent at any time.

Signature: _____

Please Print Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____