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

Dr Jessica Mibus
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M Clinical Chiropractic
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Dr Verity Mercieca
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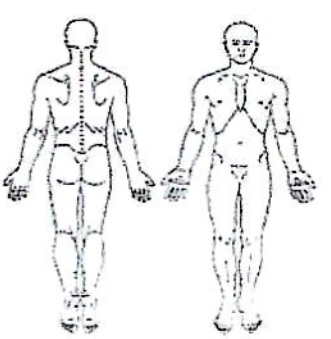
Bacchus Natural Health

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

Mr/Mrs/Miss/Ms Name: _____
Address: _____
Date of Birth: ___/___/_____ Email Address: _____
Mobile Phone: _____ Home Phone: _____
Occupation: _____Private Health Insurance? Y / N_____
Medicare Number: _____ ref (__) Student Concession? Y / N
Pensioner? Y / N Card Number: _____
Emergency Contact & Phone Number: _____
Have you previously seen a Chiropractor? Y / N How long ago if applicable? _____
How did you hear about us? Google/Friend/Family/Doctor/Other (who?) _____
Work Cover? Y / N _____ TAC? Y / N _____
Department of Veteran Affairs? Y / N _____

PLEASE DRAW ON THE DIAGRAM →

- **For pain use XXX**
- **For tingles use ///**
- **For numbness use XXX**



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

_____

_____

If you have had any x-rays or scans taken, please list where & when they were taken:

_____

_____

Any history of cosmetic implants or pacemaker surgery? Y / N

Signature: _____ **Date:** ___/___/_____

***Please note that missed appointments with less than 2 hours' notice will be charged for.**

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Dr Jessica Mibus
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Dr Laura Keating
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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 that you should be informed about.

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 appreciate that results are not guaranteed, and I acknowledge that I am aware of the rare risks associated with my care, including but not limited to:

* Muscle and joint soreness or strains
* Fractures or 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
* Nausea and dizziness
* Vascular injuries

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.

* Chiropractic care may involve the use of dry needling therapy. Dry Needling is a valuable treatment for acute and chronic pain. Like any medical procedure, there are possible complications including but not limited to; infection, hematoma (bruising) and paraesthesia (tingling sensation). In the case of needling the chest wall region, there is a rare possibility of pneumothorax (air in the chest cavity). Whilst complications are extremely rare, they must be considered prior to treatment. Patients must inform practitioners about medical conditions such as pregnancy, pace makers, joint replacements, blood borne infectious diseases, breast implants or the use of blood thinners **prior to treatment**. Please tick the following box if you **DO NOT** consent to dry needling therapy. You can alter this consent at any time.

☐ **I <u>DO NOT</u> consent to the use of dry needling therapy.**

<u>Medical Record Release Authority:</u>

I intend to give my consent to release any relevant medical results to this clinic, including X-rays, CT, MRI and blood test results. I understand I can withdraw my consent at any time.

_____ _____

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

Chiropractor's signature

_____ _____

Print Name

Date