Dr Julia Higgins
B. App. Sci (Clinical) B Chiropractic Sci.
P/N: 2240644Y

Dr Michael Landry
B. Sc, D.C. (Palmer College of Chiropractic)
P/N: 210828LX

Dr Jessica Mibus
B. App. Sci (Clinical) B Chiropractic Sci.
M Clinical Chiropractic
P/N: 4115421J

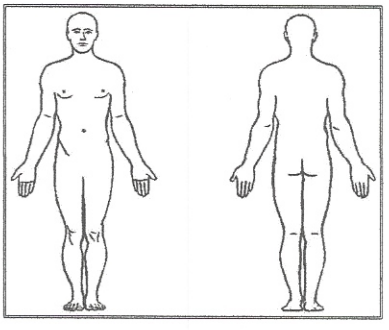
Dr Laura Keating
BHSc (Chiro) MClinChiro, MCAA
P/N: 5276832L

BALLARAT IntegratedHEALTH CENTRE

518 Mair St, Ballarat, Victoria, 3350
Ph: 5331 2669 Fax: 53312 047

Mr/Mrs/Miss/Ms First Name: _____ Surname: _____
Address: _____
Postcode: _____ Date of birth: ____/____/_____
Home phone: _____ Mobile phone: _____
Occupation_____ Private Health Fund: Y_____ N_____
Medicare Number: _____ref (___) Student Concession Y_____ N_____
Pensioner: Y_____ N_____ Card Number: _____
Emergency contact name & phone: _____
Have you previously seen a Chiropractor: Yes/No How long ago? _____
How did you hear about us? Google ___ Family ___ Dr___ Friend ___Other (who?) _____
Work Cover: _____ TAC: _____
Email address: _____

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? Y _____ N _____

***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 that you should be informed about.

I acknowledge that I have discussed with Dr Julia Higgins, Dr Jessica Mibus, Dr Laura Keating, Dr Michael Landry, 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.

Medical Record Release Authority:
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.

* 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), paraesthesia (tingling sensation) which may continue for a brief moment. In the case of needling in 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 **DO NOT** consent to the use of dry needling therapy.

Patients Name (print) **Date**

_____ _____

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

_____ _____