Grand Boulevard Chiropractic Centre

Client Consent Form

CONFIDENTIAL

REQUIRED

Please complete this form before your appointment.

Name: _____ Male / Female _____

Address: _____

Suburb: _____ Post Code _____

Phone (H): _____ Phone (M): _____

Emergency Contact: _____

Are you taking any medication?

_____

OPTIONAL

Occupation: _____

Recreational Activities: _____

How did you find out about us?

_____

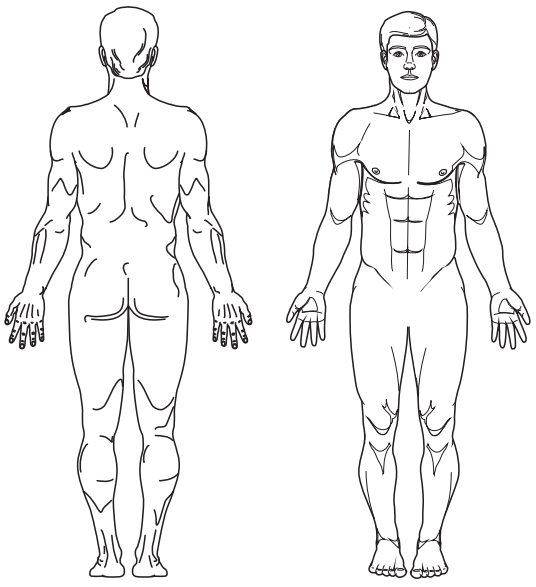
There is always some risk associated with any treatment such as bruising, sleepiness or fainting. The best way to reduce the chance of risk occurring is to answer all the questions about your health, fully and honestly. The therapist will explain the treatment to you before they commence but you must ask if you require further explanation or have specific questions.

Please complete the following assessment:

✓

Please indicate if you have recently had any of the following:			
	Cancer		High Blood Pressure
	Chronic Pain		Joint Replacements
	Cold / Flu		Kidney Ailments
	Diabetes		Loss of Balance
	Dizziness		Neck or Spine Injury
	Headaches		Numbness
	Heart Problems		Pregnant
	Herpes		Skin Disorders
	Allergies:		
	Other:		

Please identify problem areas:



Please tick the boxes once read and sign and date the Consent

☐ I verify that the client information and history given, is, to the best of my knowledge, true and accurate and I undertake to advise the therapist of changes that may occur in any of my conditions at any future massage treatment that may occur.

☐ I hereby give my consent to this treatment.

Signature: _____ Date: _____