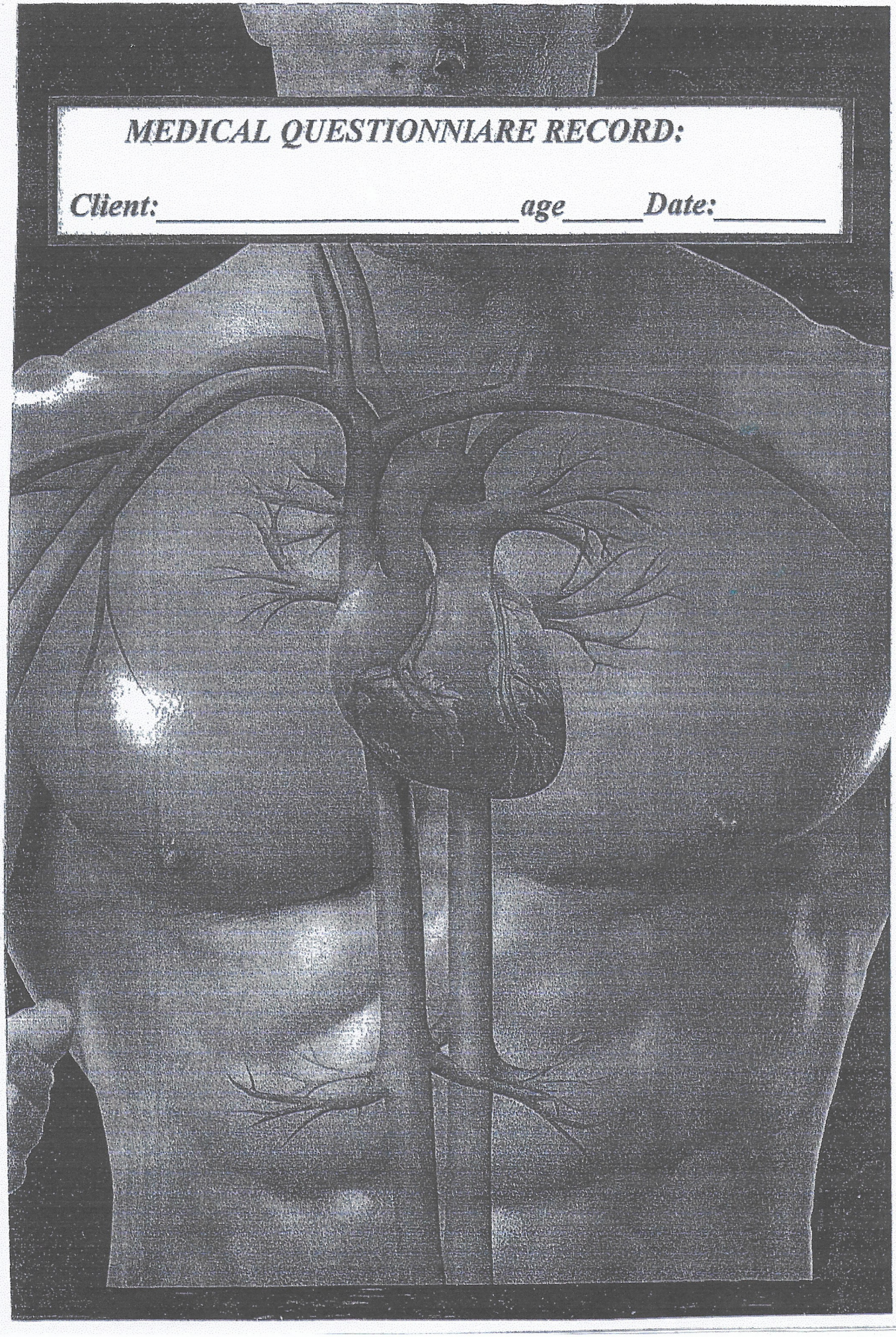

MEDICAL QUESTIONNIARE RECORD:

Client: _____ ***age*** _____ ***Date:*** _____

Table 15.6. Sample of a basic screening test.

EXERCISE SCREENING QUESTIONNAIRE.

Name:.....Age:.....

Please tick the appropriate boxes.

Has your Doctor ever said that you have a heart problem?	YES	NO
Do you frequently have pains in your chest or heart?	YES	NO
Do you often faint or suffer from severe dizziness?	YES	NO
Has your Doctor ever said that your blood pressure is high?	YES	NO
Do you have any joint problems? (eg. sprains, arthritis...).	YES	NO
Are you over 40 years old and not accustomed to regular exercise?	YES	NO
Are you pregnant?	YES	NO
Are you currently taking any medication, feeling unwell or injured?	YES	NO
Have you recently undergone surgery or treatment for any medical condition?	YES	NO
Is there any other reason not mentioned above why exercise may prove uncomfortable or harmful?	YES	NO

If yes, please state the reason below:

.....

.....

.....

.....

Signed:..... Date:...../...../.....

Should a participant answer yes to any of the above questions he or she should be required either to complete a more comprehensive screening test (see Table 15.7) for evaluation by an exercise physiologist or referred to a medical practitioner for medical clearance prior to commencing an exercise programme.

Table 15.7. Sample of a more comprehensive screening test.

MEDICAL SCREENING QUESTIONAIRE

This form is to be completed by the client, prior to the commencement of any exercise programme.

1.0 Personal

Name: (Surname)_____ (Given names):_____

Sex:_____ Date of Birth:_____ Age:_____

Address (home):_____

Suburb:_____Postcode:_____

Telephone: (Home): ( )_____ (Work):( )_____

1.1 Doctor

Name:_____

Address:_____

Suburb:_____Postcode:_____

Telephone: (Bus.hrs): ( )_____ (Aft.hrs): ( )_____

Date of last Medical Examination:_____

1.2 Emergency

In case of an emergency, please notify:

Name:_____Relationship:_____

Address (home):_____

Suburb:_____Postcode:_____

Telephone: (Home): ( )_____ (Work):( )_____

2.0 Family History

Please identify any health problems that have occurred in your immediate family.

Condition	Yes	No	Relationship to you	Present Age	Age of Onset	Fatal - Yes / No
High Cholesterol						
High Blood Pressure						
Angina						
Heart Attack						
Stroke						
Obesity						
Diabetes						
Asthma						
Cancer						

Other_____

3.0 Personal Medical History

I have had, or been told I have, or consulted a physician for:

Condition	Y/N	Condition	Y/N	Condition	Y/N
Heart Disease		Diabetes		Rheumatic Fever	
High Cholesterol		Epilepsy		Angina	
High Blood Pressure		Cancer		Arthritis	
Stroke		Menstrual Disorders		Chest Pain	
Migraine		Pneumonia		Chronic Headaches	
Asthma		Joint Problems		Bronchitis	

Others / Give Details:_____

Possible additions*Mental Disorders eg: -Asperges Syndrome?-Depression?-Schizophrenia?
*Anaphylactic reactions? eg; Nut Allergies? other Allergies? eg:-Bee stings?-Seafood?
*Thyroid disease? eg:Hypothyroididism? Hyperthyrodism?

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (health care providers name).

Dated this _____ day of _____ 20___

_____
Patient signature (or Legal Guardian)
Print Name:_____

_____
Signature of Witness
Print Name:_____

This form is to be completed by every client of Healy's Musculo Skeletal Therapies

RELEASE AND INDEMNITY

I _____ do understand and acknowledge the above information as forming and being an integral part of the Curriculum Vitae of Mr. Graham Healy. I understand and acknowledge that Mr. Healy, although working towards achieving the title of Doctor of Chiropractic has not yet achieved that title and the qualification that goes with it.

I further understand and accept that any treatment I agree to have provided to me by Mr. Healy will be in accordance with the information given above and based on courses studied by Mr. Healy up to this point.

I therefore fully and irrevocably release, indemnify and forever hold harmless Mr. Graham Healy of any and all damage, harm or injury that may be incurred by my person as a result of my requesting and agreeing to be treated by Mr. Healy.

Furthermore, I understand and acknowledge that I have in no way been coerced or manipulated into having these treatments provided to me by Mr. Healy or any other person associated with Mr. Healy and I have permitted these treatments of my own volition and undertaking knowing full well that I accept entirely the responsibility and repercussions of my own actions.

Name: _____

Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____

I have read and understood the above declaration

_____ **Date**_____

Signature

notes kept reference Client medical record progressive

Note: if any medical event occurs or injury a record is kept below and follow up result signed off

Name	Date	Comments	Advice /Action