I GIVE MY CONSENT FOR THE CHIROPRACTOR TO TREAT THE FOLLOWING, AND TO USE THE FOLLOWING TECHNIQUES:-

ACUPUNCTURE	☐ DATE.....SIGNED.....	DATE.....SIGNED.....
NECK	☐ DATE.....SIGNED.....	DATE.....SIGNED.....
THORACIC AREA (MID BACK)	☐ DATE.....SIGNED.....	DATE.....SIGNED.....
LUMBAR AREA (LOW BACK)	☐ DATE.....SIGNED.....	DATE.....SIGNED.....
LEFT AND / OR RIGHT UPPER LIMB (ARM AND HAND)	☐ DATE.....SIGNED.....	DATE.....SIGNED.....
LEFT AND / OR RIGHT LOWER LIMB (LEG AND FOOT)	☐ DATE.....SIGNED.....	DATE.....SIGNED.....

****

Do you experience any of the following: - Please Tick

NEURO	Fits	Dizziness	Shaking	Weakness	Pins+Needles	Headaches	Fainting	Incoordination	Paralysis
	☐	☐	☐	☐	☐	☐	☐	☐	☐

Has any member of your family ever suffered from any of the following:- Please Tick

FAM HIST	Diabetes	Cancer	Heart	BP	Epilepsy	Nervous	Stroke	Arthritis	Blood Disorder
	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOW DO YOU RATE YOUR PAIN, ON A SCALE OF 0 - 10? 0 = No pain & 10 = Severe pain.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐