OHP Client Information and Consent Form

Name: _____

Mobile #: _____ **Home #:** _____

Email: _____ **D.O.B.:**_____

Home Address: _____

Occupation:_____ **Emergency Contact + Ph #:** _____

Do you have Referral DVA, Work Cover, EPC or CTP Insurance Claim? Y /N: _____

GP Name: _____ **Suburb:**_____ **GP Phone #:** _____

Do you have any allergies? Y / N Please give details: _____

Do you have pacemaker / other implants? Y / N _____

Have you had surgery within the past 12 months? Y / N please give details _____

Current Medication: _____

Relevant Medical History: _____

Your Consent

Your consent is required to provide treatment, retain your information on our database and share (if necessary) with your referring GP or Medical Practitioner for the purpose of reporting on your condition after your assessment and treatment.

I, _____ (Full Name) give my consent to provide treatment and retain information provided in this form for the purpose as stated above.

Could you please TICK the boxes below giving your consent to the different treatments OHP offers:

Physiotherapy **Spinal Manipulation** **Acupuncture** **Dry Needling**

Signature: _____ **Date:**_____

Please note that we have a 24 hour Cancellation Policy. Charges may apply.