metamed
integrative and intuitive healthcare

25a Russell Street
24 Helwick Street
Wanaka, 9305
P: 03 443 2628

Level 1 Rees House
Remarkables Park
Frankton, Queenstown
P: 03 451 1342

Patient Information

Title: (please circle) Mr. Mrs. Ms. Miss. Dr.

Name: _____Date of birth:_____

Address:_____

Suburb:_____Postcode:_____

Phone-Home:_____Mobile:_____

Email:_____Occupation:_____

GP:_____ and/or Clinic:_____

Other health practitioners:_____

Medical History

Please list any current medical conditions:

_____

_____

Please list any **family history** of medical conditions or disease:

_____

_____

Please list all prescription medications, including natural remedies or supplements you are currently taking:

_____

_____

Please list **ANY** hospitilisations, surgery, injuries, fractures or major accidents: (event and approximate date)

_____

_____

How did you find out about MetaMed? (please specify)

☐ Referred by friend ☐ Referred by health practitioner ☐ Google search

☐ Other, please let us know how you found us: _____

Please read and sign the next page.

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Informed Consent

When performed by a qualified practitioner *osteopathy* is an effective and safe method of treatment for many conditions. However, you must recognize there are risks as with all health care procedures, which you should be informed about. Please read the following carefully and discuss any concerns you have with your treating practitioner. If you consent to treatment please sign and date below.

I hereby request and consent to the performance of osteopathic treatment including cervical manipulation (if required) and other therapies (soft tissue massage, medical acupuncture, joint manipulation, stretching, cupping and exercise prescription; Western herbal medicine and psychosomatic therapy) to be used on me by Osteopaths and other health practiioners working for MetaMed.

I have disclosed all relevant health information to enable the treating practitioner to screen me safely for potential risks and use of certain therapies. I will update the treating practitioner of any changes to this medical history at subsequent consultations.

I understand that results are not guaranteed, and may in some cases feel sore for a day or two after treatment.

I understand and I am informed that, as in the practice of medicine, in the practice of osteopathy there are some risks associated with treatment, including, but not limited to: muscle and joint soreness, bruising, muscle strains, joint sprains, fractures, disc injuries, nerve injuries, and more severe risks including stroke and stroke-like episodes.

Cancellation policy: 48 hours notice is required to cancel or reschedule your appointment. A cancellation fee of $95 will be charged if less notice is given or you do not attend your appointment.

Privacy policy: All information relative to your case is held in total confidence. Consent is required to allow the exchange of information between other health care practitioners for proper and effective management of your condition.

I have read the above and I have also had the opportunity to ask questions about its content and discuss the nature and purpose of treatment.

Patient's Name:

_____
Patient/Parent/Guardian

Signature:

_____
Patient/Parent/Guardian

Date: _____