Adam Kay
CHIROPRACTOR

New Patient Registration

Personal Details

Title…….. First Name…… Surname ……..

Full Address & Post Code ……..

…… Date of Birth……..

Home Telephone …….. Mobile Telephone ……..

Email ……..

Marital Status …… Number & Age of Children ……..

How did you hear about the clinic? ……..

Do you intend to claim your fees through health insurance Y/N If yes, which company? ……..

Occupational Details

Occupation …….. No. of years in current job ……..

What does your job involve? (e.g. sitting, lifting) ……

Health Details

What brings you here today? ……..

Name of GP …….. GP Surgery ……..

Current medication ……..

Previous hospitilisations ……..

Previous X-Rays/MRI/CT ……..

Are you pregnant? Y/N Date of last menstrual period ……

Do you smoke? Y/N No. per day …… Do you drink? Y/N No. units per week ……..

Do you take any supplements? ……..

Consent

I understand that I will be required to pay for treatment at the time of each visit. If I cancel or reschedule an appointment with less than 24 hours' notice, I agree to pay the applied charge.

Any insurance claims are to be dealt direct with the provider. A GP referral may be required for claims to be processed. The clinic does not accept any responsibility should a claim not be accepted.
The clinic may choose to contact you, using contact information provided, to let you know about matters relating to the clinic. You may choose not to receive this information by letting us know.

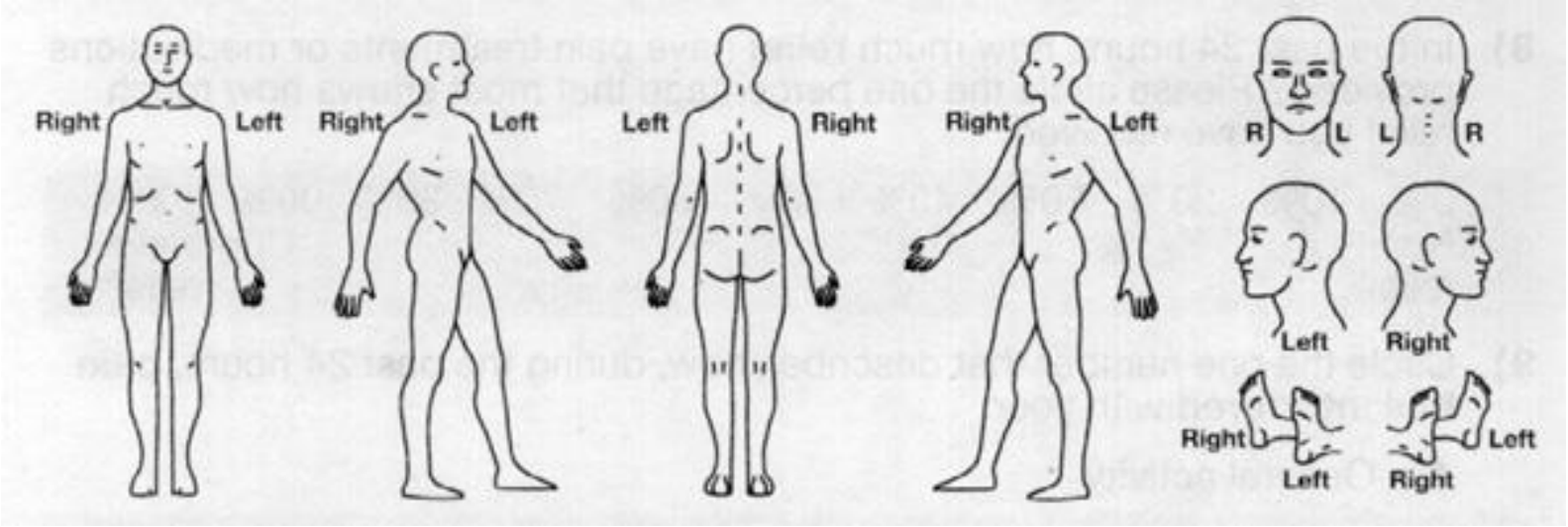
Under the new General Data Protection Regulations (2018) we are required to advise you of our Data Protection Policy. As part of the patient record, this clinic is required to retain information for the purpose of consultation, for treatment, recording subsequent treatments and for the use by third party medical practitioners only at the request of the patient in writing.

Please indicate if you either currently or previously have suffered with any of the following conditions:

Heart/Circulation/Blood pressure		Nervous System (e.g. MS, Epilepsy)		Tiredness/Lack of energy	
Backache/Trapped nerves		Joints		Breathing trouble	
Arthritis		Cancer		Anxiety/Depression	
Digestive system		Skin		Ears/Nose/Throat	
Bowels/Bladder		Osteoporosis		Eyes	
Reproductive System		Whiplash		Diabetes	
Headaches/Migraines		Stroke		Weight	

Pain Diagram

Please shade the areas of pain you are experiencing



Out of 10, please indicate your level of pain ...../10

I confirm that the information given above is true to the best of my knowledge and belief. I understand that the Chiropractor may wish to undertake an appropriate physical examination, to which I hereby consent.

Upon completion of this form all paper files and electronic records will be kept for as long as the patient remains a patient of the clinic and thereafter for a period of 8 years. All information is confidential and will not be given to any person or organisation without the written consent of the patient concerned. All data is held securely either electronically or on paper in files accessible only by clinic staff who are directly involved in the data entry and processing of patient records. I give my consent to the clinic to maintain my records for the purpose outlined as above.

Signed by Patient ……

Date ……,,,,,,,,../……,,,,,,,,../……,,,,,,,,..

Signed by Chiropractor ……

Examination:

I hereby give my consent to the chiropractor performing a physical exam.

Initials_____

Treatment:

I have been given a verbal report of findings regarding my condition. I have been advised of and understand the benefits and risks of chiropractic treatment and have had all my questions answered to my satisfaction. I hereby consent to treatment as outlined to me.

Initials _____

Email contact:

I am happy to be contacted by email regarding appointments

Initials_____

and clinic newsletters

Initials_____

GP Referral:

I give my consent for the clinic to contact my GP in case of emergency or if clinically indicated.

Initials_____