Confidential Patient Information

Personal Information

Full Name: _____
Last First Title

Address: _____
Street Address

_____
City County Postcode

Date of Birth: _____ Age: _____

Home Phone: _____ Mobile: _____

E-Mail: _____ Occupation: _____

Status: **Single/Married/Widowed/Divorced**

GP Name & Address: _____

Medical History

Have you ever suffered from any of the following? (Please Tick)

Dizziness	Bladder, Urinary Complaints
Backaches	Epilepsy
Heart Trouble	Digestive Disorders
Diabetes	Cancer
Tuberculosis	Blood Pressure
Arthritis	Thrombosis
Headaches	Chest Problems
Strokes	Asthma
Rheumatic Fever	Smoking/Vaping

Operations: _____

_____

Accidents: _____

_____

Current Medication: _____

_____

1. Have you ever been on steroids: YES / NO
2. Have you ever been treated for any health condition by a Doctor/Therapist in the last year? YES / NO
3. Do you have any objection if we contact your GP? YES / NO
4. Have you had X-Rays in the last 6 months? YES / NO
   If yes which area of the body did you have X-Rays on? _____

Purpose of Visit / Goals

What has caused you to make your appointment today? _____

Do you have an activity / goal that you are currently unable to do? _____

How did you Hear about Us?

Person's Name: _____ Other: _____

Insurance Claims

Please Complete this section if you are planning to claim for your care here through an insurance company;

Insurance Company: _____ Policy Number: _____

Claim Number: _____

I understand and agree that health accident policies are an arrangement between an insurance carrier and me. Furthermore, that Natural Chiropractic Ltd, will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Natural Chiropractic Ltd will be credited to my account on receipt. **I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or cease my care/treatment, any fees for professional services rendered to we be immediately due to Natural Chiropractic Ltd.

Consent to physical Examination

Your chiropractor is about to perform a physical examination to help establish your diagnosis. This requires him/her to preform physical, postural, orthopaedic, neurological and chiropractic tests, used throughout the medical and chiropractic fields. If some do not appear reverent to you, please be reassured that the chiropractor needs to have an assessment of the overall state of your health which can influence your joints and nervous system. You will be asked to preform certain actions and your chiropractor will be looking to test your motion and signs of pain. Sometimes your pain maybe reproduced or you may experience some soreness, which usually abates quickly. Please let your chiropractor know if any part of the examination causes discomfort.

I consent to physical examination from the chiropractor:

Patient Signature: _____ Date: _____

Data Protection

Natural Chiropractic is required to retain information (including X-rays) for the purpose of consultation and treatments. All information provided by you will be treated as confidential, and will not be given to any other person(s)/organisation(s) without the written consent of the patient concerned, unless the clinic changes ownership and is passed in to another GCC registered chiropractor. **A copy of your notes and x-rays can be gained by requesting then (with advance notice). The originals are the property of the clinic.**

I understand and consent to the above terms:

Patient Signature: _____ Date: _____

Clinic Contact

Natural Chiropractic clinic may need to contact you via text or email to remind you of appointments, notifications, promotions or send you a newsletter. Please circle all the methods of contact you are happy for us to contact you by

Methods of Contact: **Post / E-Mail / Text / Phone**

Feedback

If you have had a positive experience, or would like to let us know your comments (positive or negative), we always welcome feedback. We also have a practice complaints procedure to help resolve any problems.

Office Use Only

Information Collected by CA: _____ Date: _____

Capacity for Consent: _____