Patient No.		Date	

Confidential Patient Health Records

Personal details - Please print carefully and clearly

Forename(s)			Surname		
Title		Date of Birth		Age	
Home Address					
Preffered Contact Number					
Emergency Contact Name/Number					
Email Address					
Occupation			Number of years in occupation		
How did you hear about this clinic?					

If you have been referred by one of our patients, we send them a thank you card with £5 discount towards their next appointment.

Is this acceptable? Y ☐ N ☐

GP Details

GP Name: ..... Tel: .....

Address: .....

..... Post Code: .....

Health Insurance

Are you covered by health insurance? Y ☐ N ☐

If **Yes**, which company .....

If you have private health insurance and wish to claim for your treatments, please call the company and obtain an authorisation code. Once we have the code we are happy to invoice the company direct.

Any excess on your policy must be paid to the clinic at the beginning of your treatments. This is held as a credit on your account.

Privacy Statement

We take your privacy very seriously

All personal information is treated in the strictest confidence, and is not passed to any unrelated third parties, and used only in accordance to the services provided.

Contacting you.

We will contact you by phone/text/email with information as necessary and only in relation to your appointments and the course of treatment/s that we are providing for you.

We send out a monthly Newsletter with discounts available, clinic updates, health tips and information about our services (you may unsubscribe at anytime) **Opt in** ☐

Terms and Conditions

Payment of all fees shall be made at the time of each visit.

If any appointment is cancelled or postponed with less than 24 hours notice, a full payment fee may be charged.

If you are late for an appointment we cannot guarantee that you will be seen and you will be charged.

Ownership of all x-rays and records will remain the property of the clinic. Records may be copied upon written request and may incur a charge.

I consent to an examination relevant to the received therapy.

Respectful behaviour to staff and clinicians is expected at all times.

I have read and understood the terms and conditions above and all the information given above is correct to my knowledge (please sign below).

Signed ..... Date .....

In the event of any complaints please contact the Practice Manager.

Patient No.		Date	

Health Details

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

Heart / circulation / blood pressure		Eyes	
Stroke		Migraines / headaches	
Respiratory (breathing / lungs)		Joints / Arthritis	
Digestive system		Depression / Anxiety	
Bowels		Weights	
Urinary tract (kidneys / bladder etc.)		Mental Disorder	
Reproductive system		Cancer	
Liver and gall bladder		Nervous system (e.g. MS, epilepsy)	
Ears / Nose / Throat		Skin	
Diabetes		Osteoporosis	
Are you or is there any chance that you are pregnant? Have you previously been pregnant?	Y ☐ N ☐ N/A ☐		

Current Medication			
Significant previous physical or emotional trauma			
Any previous operations/ hospitalisations (Date/Year)			
Previous X-Ray/CT/MRI (Date/Year)			
Do you smoke?	Y ☐ N ☐	No. per day	
Do you drink?	Y ☐ N ☐	No. of units per week	
Have you consulted your GP about any other medical condition recently?	Y ☐ N ☐		
Details			
Height		Weight	
Other (non medical) treatments			