Welcome to healthy for life!

New Client Details Form

Surname: Age:

Forename(s): DOB:

Address:

Post Code:

Home Tel: Work Tel:

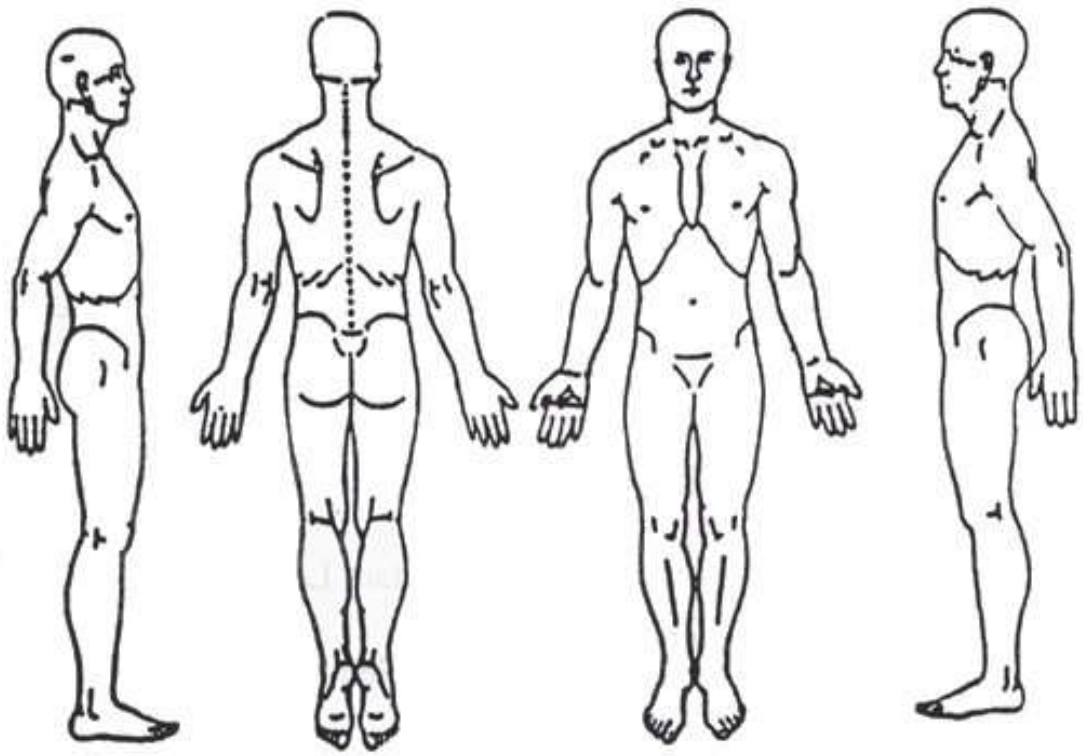
Mobile: Email:

Occupation:

How did you hear about us? (If recommended, by whom?)

Name and Practice of GP

Please mark below the location of any symptoms that may have brought you here today?



Please list any medication and supplements you are taking:

Please list with dates any previous surgery

P.T.O.

Patient Consent Form

Patient Name_____**Date of birth**_____

Please read, initial each consent part and sign and date at the bottom. Please note that you do not have to sign the consent to treatment before you have discussed your condition and treatment options with the 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_____

Data Protection:

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. 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.

Patient Signature _____ Date_____