Family Chiropractic

Patient Information

Name _____ D.O.B _____

Address _____ Post code _____

Mobile _____ Other Phones_ (_____) _____

Email _____

Occupation _____ If you have children, please list their age _____

GP Surgery name & address _____

I consent to the chiropractor sharing my medical information with my GP ☐ Yes ☐ No

Whom may we thank for referring you to our clinic? _____

Are you currently pursuing an insurance claim for personal injury? _____

Your Health Profile

(Please tick the appropriate box)

	Yes	No	Unsure
Did you have any serious falls or physical traumas as a child?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Any prolonged use of medicines such as antibiotics or an inhaler?	☐	☐	☐
As a child were you under regular Chiropractic care?	☐	☐	☐

Comments: _____

_____

	Yes	No	I used to
Do did you smoke / vape? If yes, how many per day _____	☐	☐	☐
Do/did you drink alcohol? If yes, how many per day _____	☐	☐	☐
Do you drink Coffee, tea or other caffeinated drink? If yes, how many cups per day _____	☐	☐	☐
Have you been in any accidents?	☐	☐	
Have you had any surgery? _____	☐	☐	
Do/did you take any medications/drugs? _____	☐	☐	
Do/did you play any sports? _____	☐	☐	

On a scale of 1 to 10 describe your current health: (1 = Poor, 10 = Excellent)

Poor 1 2 3 4 5 6 7 8 9 10 **Excellent**

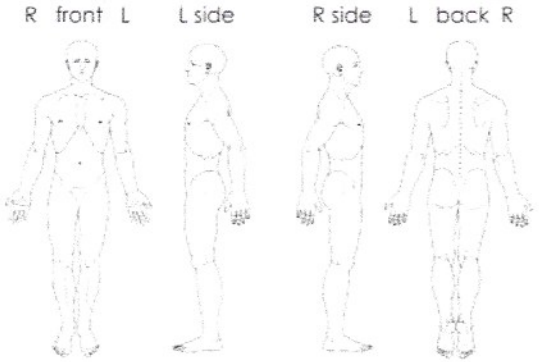
On a scale of 1 to 10 describe where you would like your health to be: (1 = Poor, 10 = Excellent)

Poor 1 2 3 4 5 6 7 8 9 10 **Excellent**

Are you seeking from your chiropractor ☐ Pain relief Or ☐ Pain relief & Correction / Rehabilitation

Addressing the issues that brought you to this office

Please indicate the areas where you are experiencing symptoms on the below



Please describe your pain
(tick appropriate box)

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Constant

Chief complaint and cause _____

What caused your symptoms to start? _____

How long have you been experiencing this problem? _____

Since the problem has started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? _____

Indicate what your present condition is affecting: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Rate your level of pain (please circle): **No pain** 1 2 3 4 5 6 7 8 9 10 **Severe pain**

Have you seen other health professionals about this problem? ☐ Yes ☐ No

If yes, please list: _____

Have you previously had diagnostic imaging: ☐ X-ray ☐ MRI ☐ Computerized Nerve Scan

Medical History

Please tick all symptoms you have ever had, even if they do not seem related to your current problem.

Musculoskeletal system
__Scoliosis
__Jaw Pain
__Neck pain
__Whiplash
__Back pain
__Hip pain
__Leg pain
__Knee/foot pain
__Arm pain
__Wrist/hand pain
__Fracture
__Osteoporosis
__Arthritis
__Morning stiffness
__Tendinitis
__Muscle weakness
__Disc problem
__Hernia

Nervous system
__Memory Loss
__Migraine
__Headache
__Epilepsy
__Fibromyalgia
__Sciatica
__Pins & Needles

Respiratory/CV systems
__Chest pain
__Shortness of breath
__Fainting
__Asthma
__Heart problem
__Lung problem
__Poor circulation
__Leg cramps
__High blood pressure
__Stroke

Eye-Ears-Throat
__Vision disturbance
__Sinus Problem
__Vertigo/Dizziness
__Ringing in ears
__Ear infection
__Difficulty swallowing
__Throat infection

Digestive System
__Diabetes
__Heart burn/acid reflux
__Stomach pain/ ulcer
__Constipation
__Diarrhea
__Liver problem
__Gallbladder problem
__Irritable bowel
__Haemorrhoids
__Eating disorder

Urinary Tract
__Kidney problem
__Bladder problem
__Incontinence
__Urinary tract infection

Women
__Endometriosis
__Fibroid
__Menstrual cramps

Men
__Prostate problem
__Impotence

Other
__Sleeping problem
__Depression/anxiety
__HIV/AIDS
__Thyroid problem
__Cancer
__Allergies

The statements made on this form are accurate to the best of my knowledge. I consent to this information and any subsequent information regarding my examination and treatment to be retained and stored by Family Chiropractic in accordance with the clinic policy and the Data Protection Regulation (GDPR) (EU) 2016/679

Signed* _____ Date _____

*Please note, if the patient is under 16 years of age, a parent or legal guardian is required to consent on their behalf by signing this form. Please also print your name and state your relationship to the patient.

PATIENT CONSENT FORM

Name: .....Date of birth: .....

CONSENT TO EXAMINATION

I consent to an appropriate physical examination.

Signed:..... Date: .....

If you are under 16 years of age, a parent or legal guardian is required to sign this consent.

Signed: .....Date: .....

CONSENT TO X-RAY EXAMINATION

I have been informed and I understand the clinical reason why an x-ray examination is required, and I consent to the procedure.	
I understand and agree that any x-ray taken by this clinic in an important part of my permanent record and as such must remain the property of the clinic for the next 8 years.	
I have been informed of what is involved and the risks.	
Women Only (we require the following information) Date of your last period: .....Is there any possibility of you being pregnant? ☐ Yes ☐ No	

**If you are under 16 years of age, a parent or legal guardian is required to sign this consent*

Signed: .....Date: .....

CONSENT TO TREATMENT

- I have been given a report of findings regarding my condition and the available treatment.
- I have been advised of the course of treatment and I understand the compliance to the recommended treatment schedule is important to treatment success.
- I have been advised of and understand the possible risks to treatment and had all my questions answered to my satisfaction.
- I consent to treatment as outlined to me.

Signed: .....Date: .....

If you are under 16 years of age, a parent or legal guardian is required to sign this consent.

Signed: .....Date: .....

GDPR

I hereby consent to this information and any subsequent information pertaining to my examination and treatment to be retained and stored by this clinic (Family Chiropractic).
In accordance with the clinic privacy policy and the General Data Protection Regulation (GDPR)(EU) 2016/679.

Client signature..... Date.....
Parent or guardian (if client is under 16 years old) .....

Family Chiropractic

PREGNANCY STATUS QUESTIONNAIRE

Patient's name: .....

DOB: .....

TO BE COMPLETED BY ALL FEMALE PATIENTS BETWEEN THE AGES OF 16 AND 55;

GIRLS UNDER 16 YEARS OF AGE WILL ONLY BE IMAGED DURING THE FIRST 5 DAYS OF THEIR PERIOD.

To avoid irradiating an undiagnosed or early pregnancy, could you please complete this form:

1. Is there any possibility you could be pregnant? .....
2. What was the start date of your last period? .....
3. Are you using reliable contraception? .....
4. If 'yes' to previous question, please specify .....
5. Have you had sex since the start of your last period? .....
6. Have you been sterilised (tubes cut or tied)? .....
7. Has your partner had a vasectomy? .....
8. Have you had a hysterectomy? .....
9. Have you gone through the menopause? .....

Please sign and date this form.

Signature..... Date.....

Checked ☐ Accepted / Declined

OK to continue with examination? YES / NO

Operator's signature .....

Date .....

Comments

FOR DOCTORS USE ONLY

Exam by.....

Date.....

Clinical Reasons for X-Ray

.....

.....

Series.....

Diagnosis

.....

.....

Treatment Plan

.....

.....

Re-evaluation.....

Red Flags.....Date.....

Yellow Flags.....Date.....

Reported by.....

Doctors Notes

FAMILY CHIROPRACTIC - GDPR - PRIVACY NOTICE

Why we collect your personal data, what we do with it:

When you supply your personal details to this clinic they are stored and processed for 4 reasons (the bits in bold are the relevant terms used in the Data Protection Act 2018, which includes the General Data Protection Regulation)

1. We need to collect personal information about your health (or in the case of minors, their health with the consent of the parent or guardian) in order to provide you with the best possible treatment. Your requesting treatment and our agreement to provide that care constitutes a **Contract.** You can, of course, refuse to provide the information but if you were to do that, we would not be able to provide treatment.
2. We have a **"Legitimate interest"** in collecting that information, because without it we couldn't do our job effectively and safely.
3. We also think that it is important that we can contact you in order to confirm your appointments with us or to update you on matters related to your medical care. This again constitutes **"Legitimate interest"**, but this time it is your legitimate interest.
4. Provided we have your **consent**, we may occasionally send you general health information in the form of articles, advice or newsletters. You may withdraw this consent at any time, please let us know by any convenient method.

We have a **legal obligation** to retain your records for 8 years after your most recent appointment (or until age 25, if this is longer), but after this period you can ask us to delete your records if you wish. Otherwise, we reserve the right to retain your records indefinitely in order to provide you with the best possible care should you need to see us at some future date.

Your records are stored:

1. On paper, in locked filing cabinets; the offices are always locked out of working hours.
2. Electronically on our office computers, which are password protected and backed up regularly, and the offices are always locked out of working hours.

We will never share your data with anyone who does not need access, without your written consent. Only the following people/agencies will have routine access to your data:

- The medical records service who store and process our files
- Your practitioner(s) in order that they can provide you with treatment
- Our reception staff, because they organise our practitioners' diaries, and coordinate appointments and reminders (but they do not have access to your medical history or sensitive personal information).

You have the right to see what personal data of yours we hold, and you can also ask us to correct any factual errors. Provided the legal minimum period has elapsed, you can also ask us to erase your records. We want you to be completely confident that we are treating your personal data responsibly, and that we are doing everything we can to make sure that the only people who can access that data have a genuine need to do so.

Of course, if you feel that we are mishandling your personal data in some way, you have the right to complain. Complaints need to be sent to the **"Data Controller"** details for that as follows:

ukchiro@tiscali.co.uk Tel 01342 315298 Old Station House, London Road, East Grinstead, RH19 1ET
If you are not satisfied with our response, then you have the right to raise the matter with the ICO.