

**PATIENT CONSENT FORM**  
**ENGLAND, WALES & NORTHERN IRELAND**

Name \_\_\_\_\_ Case \_\_\_\_\_

**Consent to Examination**

I consent to an appropriate physical examination. I have seen the complaints procedure and understand that it is available to me at any time.

Signed \_\_\_\_\_ Date \_\_\_\_\_

If you are under 16 years of age, this form should be signed by a parent/legal guardian.

**Consent to X-Ray Examination**

I have been informed of the clinical need for an X-ray examination and consent to this procedure.

Signed \_\_\_\_\_ Date \_\_\_\_\_

If you are under 16 years of age, this form should be signed by a parent/legal guardian.

**2<sup>nd</sup> Visit**

**Consent to Treatment**

I have been given a verbal report of findings at which my diagnosis and treatment plan were fully explained. I agree to treatment in the following areas:

- Neck
- Upper back
- Lower back
- Other

The risks and benefits of treatment have been explained to me and I have had the opportunity to ask questions.

I consent to chiropractic treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

If you are under 16 years of age, this form should be signed by a parent/legal guardian.

### **DATA PROTECTION POLICY**

Under the data protection (1998) Act, we are required to advise our patients on 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 use by third party medical practitioners only, at the request of the patient, in writing.

Upon completion of the patient Details form, Data protection and consent form, all paper files and information therein may be electronically scanned and stored on computer file for as long as the patient remains a patient of the clinic; and thereafter for a period of 7 years. Alternatively paper records will be retained for the same period.

All information provided 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.

Information will be held both manually and electronically in files accessible only by staff of the clinic who are directly involved in the data entry and processing of patient records.

I the undersigned (or authorised guardian)\*\* acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the practitioner / chiropractor to maintain records for the purpose outlined within the policy.

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

\*\* For patients under the age of 16, a parent/guardian is required to sign.

### **PAYMENT**

I fully understand that payment is entirely my responsibility, even if claiming through insurance.

Patient: \_\_\_\_\_  
(Print name)

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### **GP Letter**

It is clinic policy to write to your GP, inform them about your condition and report your progress.

I **do/do not** give my consent for the clinic to write to my GP

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

# CONFIDENTIAL HEALTH QUESTIONNAIRE

Title: Mr / Mrs / Miss / Ms / Dr _____	Married: _____ Children: _____
Full Name: _____	Date of Birth: _____ / _____ / _____
Home Address: _____	Occupation: _____
_____	Telephone Numbers _____
Post Code: _____	Home: _____
GP Name and Surgery: _____	Work: _____
_____	Mobile: _____
_____	Email: _____

Present Complaint?

Date of onset?

What aggravates it?

What helps it?

Have you had any previous treatment?  
If yes, what was the diagnosis?

Are you on any Medication?

Have you had relevant X-Rays?

Do you want to: ....

- Just get out of pain?
- Get out of pain and stop it returning?
- Keep healthy once you are right?

How did you hear about the clinic

GP  Advertisement  Friend  Current Patient  Yellow Pages  Outdoor Sign

Other: \_\_\_\_\_

Have you ever suffered from any of the following? Please tick if appropriate



- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| Asthma <input type="checkbox"/>       | Heart Disease <input type="checkbox"/>   | Allergies <input type="checkbox"/>      | Pleurisy <input type="checkbox"/>        |
| Angina <input type="checkbox"/>       | Eczema <input type="checkbox"/>          | Hiatus Hernia <input type="checkbox"/>  | Pneumonia <input type="checkbox"/>       |
| Appendicitis <input type="checkbox"/> | Encephalitis <input type="checkbox"/>    | HIV <input type="checkbox"/>            | Polio <input type="checkbox"/>           |
| Alcoholism <input type="checkbox"/>   | Epilepsy <input type="checkbox"/>        | Jaundice <input type="checkbox"/>       | Prostate <input type="checkbox"/>        |
| Arthritis <input type="checkbox"/>    | Gall Stones <input type="checkbox"/>     | Kidney Stones <input type="checkbox"/>  | Rheumatic Fever <input type="checkbox"/> |
| Cancer <input type="checkbox"/>       | Glandular Fever <input type="checkbox"/> | Meningitis <input type="checkbox"/>     | Tuberculosis <input type="checkbox"/>    |
| Diabetes <input type="checkbox"/>     | Goitre <input type="checkbox"/>          | Mental Illness <input type="checkbox"/> |  |

Dental History:

- |  |   |
|--|---|
| Do you have pain in the jaws? <input type="checkbox"/> | Clicking jaw? <input type="checkbox"/>                            |
| Locking jaw? <input type="checkbox"/>                  | Do you grind your teeth? <input type="checkbox"/>                 |
| Do you wear dentures? <input type="checkbox"/>         | Have you ever worn an orthodontic brace? <input type="checkbox"/> |
| If yes, upper jaw? <input type="checkbox"/>            | Have you ever had dental surgery? <input type="checkbox"/>        |
| Lower jaw? <input type="checkbox"/>                    |   |

Dietary Intake Per Day:	Amount of ...	Sugar
Number of glasses/cups of ...	Water	Chocolate
	Cola	Sweets
	Coffee	Alcohol
	Tea	Tobacco

Have you ever suffered from any of the following? Please tick if appropriate

Headache	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	Deteriorating vision	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	Ear ache	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	Eye squint	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Ear Discharge	<input type="checkbox"/>
Loss of energy	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Ear Noise	<input type="checkbox"/>	Facial pain	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Nausea	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Bowel problems	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	Kidney infections	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Bloating/Gas	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Poor bladder control	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Sexual impotency	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>		

Do you play any sports, participate in activities, or take exercise?

PLEASE ANSWER GIVING DETAILS AND DATES

Have you had any surgery?

Have you broken any bones?

Have you had any accidents, e.g. vehicle/sports injury/falls?

Have you ever had major treatment, tests or x-rays?

Are you currently attending hospital or seeing a medical doctor?

Do you consider yourself to be under stress? e.g. Financial, Work, Relationship, Family?

Have you ever received chiropractic care, where and when?

FOR WOMEN ONLY

Painful Periods	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	PMT	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	Cystitis	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Menopause	<input type="checkbox"/>
Excessive Flow	<input type="checkbox"/>	Thrush	<input type="checkbox"/>	Cannot Conceive	<input type="checkbox"/>	Contraceptive Pill	<input type="checkbox"/>

Date of the onset of your last period    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To the best of your knowledge are you pregnant?    Yes     No

I DO / DO NOT CONSENT TO THE COMMUNICATION OF ALL RELEVANT INFORMATION ABOUT MY COMPLAINT TO MY DOCTOR. (please delete as appropriate)

Signed \_\_\_\_\_ Date \_\_\_\_\_

Is there anything else you would like to mention about your health?