Personal details Please provide the relevent details below.

Full Name: Mr / Mrs / Miss / Dr / Other _____

Address: _____ DOB: _____ Age: _____

_____ Telephone (home): _____

_____ Telephone (work): _____

_____ Telephone (mobile): _____

Post Code: _____ Email: _____

GP Name & Practice: _____

Would you object to us contacting your GP if required? Y/N (please circle)

How did you hear about us: _____ Occupation: _____

Private Medical Insurance: _____ Policy No: _____

Present Complaint

What is your main complaint?
Do you have any other complaints?
Have you seen anyone else regarding your complaint/s? (please give details)

Medical details Circle appropriate details and provide any relevent information.

General Health	Good/Fair/Poor	Pregnancy	Y/N	Diabetes	Y/N
Heart Problems	Y/N	Blood Pressure	Y/N	Blood Donor	Y/N
Circulatory Problems	Y/N	Epilepsy	Y/N	Needle Phobia	Y/N
Respiratory Problems	Y/N	Osteoporosis	Y/N	Arthritis	Y/N
Reproductive Problems	Y/N	Infections	Y/N	Allergies	Y/N
Multiple Sclerosis	Y/N	Weight Loss	Y/N	Cancer	Y/N
Sleeping Problems	Y/N	Anxiety/Stress	Y/N	Depression	Y/N
Bladder Problems	Y/N	Dizziness	Y/N	Tinnitus	Y/N
Bowel Problems	Y/N	Headaches	Y/N	Migraine	Y/N
Digestive Problems	Y/N	Skin disorders	Y/N	Eye Problems	Y/N
Ear/Nose/Throat Problems	Y/N	Operations	Y/N		
Relevant accidents/injuries:					
Relevant X-rays/investigations:					
Other information:					

Medication details Circle appropriate details and provide any relevent information.

Blood thinning medications	Y/N		
Prolonged use of Steroids	Y/N	Statins	Y/N
Any other current medications:			

Family History

	Heart Disease	Stroke	Diabetes	Cancer	Arthrits	Allergies	Other
Grandparents							
Parents							
Siblings							

Lifestyle Factors

Diet: What do you normally eat and drink?

How often on average do you drink the following?

Breakfast		Coffee	
		Tea	
Lunch		Squash	
		Fizzy Drinks	
Dinner		Fruit Juice	
		Alcohol	
Snacks		Water	

Activity: Provide appropriate details.

Would you class yourself as: **Active/Inactive**
Do you smoke? **Y/N** If Yes how many per day? ___ & How long? ___. If No have you ever smoked? **Y/N** & How long?___
Average weekly exercise for 30mins or more?
Please list activities:
Please list if you take any supplements (vitamins/minerals):

General Terms

Please read the information below, if you have any concerns you can discuss them with your clinician.

Your clinician will aim to assess your condition then explain and discuss your diagnosis and treatment options. You may be required to remove some items of clothing to reveal relevant anatomy and the clinician will need to have some physical contact with you in order to diagnose and treat your condition. You can refuse these actions at any time or request a chaperone by informing the clinician.

Injury from treatment has been proven to be very rare but some techniques used by clinicians may on occasions carry risk. Adjustments, manipulation or mobilisations of the spine could cause sprains, strains or rib fractures. In extremely rare cases (1 in 10 million treatments) disc injuries may occur and following neck treatments (1 in 5 million treatments) injury to a vertebral artery could cause a stroke.

All information regarding your care will be treated in confidence and only released with your express permision or if we feel it medically necessary. Your notes will be kept in lockable storage which is only accessible by clinic staff and none of your contact details will be shared with any third parties. Our privacy policy is available on request.

You are accepting our current fee structure and agree to payment at the time of treatment. Any invoices must be paid within 28 days, otherwise extra costs will be made and you may also have to pay third party debt recovery/legal fees.

A charge will be made for appointments cancelled with less than 24 hours notice and for failure to attend an appointment.

If you are dissatisfied with any part of the service you are entitled to request a copy of the complaints procedure.

Please inform the clinician if any of the details on this form change.

Declaration & Consent

I confirm the details provided are accurate and consent to the terms above.

Signed:	Date:
Clinician:	Date: