Confidential Patient Records

PERSONAL DETAILS - Please print clearly.
Surname……………………………………Title…………Age…………Date of Birth…………………

Forenames…………………………………………………………………………………………

Full Address…………………………………………………………………………………………

…………………………………………………………………………………………Post Code…………

Marital Status……………………………………Number and Ages of Children…………………………

Preferred contact tel no (1)……………………………………(2)……………………………………

E Mail Address…………………………………………………………………………………………

How did you hear about the clinic……………………………………………………………………

Do you intend to reclaim your fees through health insurance YES/NO. Which company?

Occupation…………………………………………………… No. of years in current job …….

Name of GPS Surgery and GP if known………………………………………………………….

Current Medication……………………………………………………………………………….

Any previous Operations/Hospitalisations (month/year)…………………………………………..

Significant physical or Emotional Trauma ……………………………………………………………

Have you consulted you GP recently YES/NO

Details ……………………………………………………………………………………………………

Do you smoke? YES/NO. Do you drink? YES/NO If yes, number of weekly units…………...

I confirm the above information is true to the best of my knowledge and belief. I understand that the chiropractor may wish to undertake an appropriate physical examination, to which I hereby consent.

Signature (Parent or Guardian if under age 16)…………………………………….Date………...

Data Protection Policy

Under the Data Protection (1998) Act, we are required to advise our patients of our Data Protection Policy.

As part of the Patient Record, this clinic is required to retain personal information relating to your care at our clinic. 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.

All information provided will be treated as confidential and will not be given to any other person/organisation without the express consent of the patient concerned.

I the undersigned herby give consent for Kesgrave Chiropractic Clinic to maintain records in accordance with the above stated policy.

Signature………………………………………………………………….. Date………………..

For completion only if your chiropractor advises diagnostic x-rays are required.

Consent: I consent to x-ray investigation and have received an explanation of the risks and benefits from the supervising chiropractor. I confirm that there is no possible chance of pregnancy and understand the importance of reporting this fact prior to x-ray exposure.

Patients signature……………………………………………………………… Date………………..
(Parent or Guardian to sign if age under age 16)