Confidential Patient Registration Form CMS No…….

The clinic reserves the right not to accept any patient we cannot help.

AS A WELLNESS CENTRE, SO THE DR CAN REVIEW HIS FINDINGS PROPERLY, WE DON'T TREAT ON YOUR FIRST VISIT.

PERSONAL DETAILS – Please print clearly

Title ..... Surname ..... Date of Birth: .....

First Name(s): ..... Age: .....

Full Address (including post code): ……

……

Home telephone number: ..... Work telephone number: .....

Mobile: ..... E-mail: .....

Marital Status: ..... No. of Children: ..... No of Grandchildren: .....

WHO CAN WE THANK FOR RECOMMENDING YOU .....

EMPLOYMENT DETAILS Occupation: ……..... Number of years in job: .....

HEALTH DETAILS Name of GP: …… Telephone No: ……..

Address of GP: .....

What brings you to us today: ……..……How long have you had this: ……

What do you want to achieve under our care?

- Only Relieve Your Symptoms (usually only a temporary solution)
- Correct the underlying cause of your problem
- Relieve the Symptoms, Correct the Root Cause and Prevent it from coming back (ie Maintain my wellbeing)

Have you received any other treatment or medicines in the last year? YES / NO

Details: .....

Have you recently lost or gained weight? YES / NO How much? ……..… Over what period? .....

Are you vegetarian? YES/NO Do you eat fish? YES/NO Do you take Omega 3 supplements? YES/NO

Do you take a multivitamin? YES/NO Do you take vitamin D? YES/NO Do you take probiotics? YES/NO

How much water do you drink per day? ……..

Do you smoke? YES / NO How much? …… Do you drink? YES / NO How much? .....

Do you exercise? …… How many times per week……..…….....

Consent & Declarations

Are you Pregnant? (date of LMP……..…)	Yes	No
Do you consent to us writing to your GP?	Yes	No

I understand that I will be required to pay for all services at time of visit. If I cancel or postpone an appointment with less than 24 hours notice, I agree to pay the appointment charge levied to me. I consent that any account left outstanding for longer than 30 days will be debited from by debit/credit card, details of which I have supplied below. All information provided is protected under GDPR.

Card No …… Issue No ……Expiry Date…… Sec Code……..

Are you claiming for your care with health insurance YES / NO Which insurance company? ……..

I confirm that I have read the procedure to claim on health insurance and understand any health/insurance claims are to be made directly with your company. A referral maybe required from them for claims to be processed. Also, your attending chiropractor must be a recognised provider, (this being only Dr Irwin). This clinic does not accept any responsibility should a claim be denied and if so all accounts must be settled be you directly with SpineLab.

I confirm that I have been supplied with enough information to give my informed consent to have a chiropractic examination, x-rays and treatment, under the direction of Dr Carl Irwin and his associates. I consent to my personal details being recorded for these purposes.

Your Initial Assessment Fee & Report of Findings - £57.00 (Does Not Include Treatment), X-rays are an additional £68.00. Further visits/adjustment - £46.00

By completing and signing this form you are agreeing to receive: appointment reminders, treatment info, patient newsletters and clinic offers via text, post and/or email. Should you prefer not to receive these please advise.

Copyright of all records & x-rays belong to the clinic and are not normally released direct to the patient. Where I have become a patient through a clinic promotion, spinal screening or reduced fee, I agree to pay £50.00 release fee should I wish to take copies of my x rays or records.

Signed Patient…… DC……..…….. Date……

Patient Health Questionnaire (please complete fully)

Name: **Date:** **Patient Number:**

Why have you come to see us?.....

How long have you been suffering?.....

How did it start?.....

How often does it occur?..... How long does it last?.....

Is it getting worse or not getting better?.....

Do you want us to only treat your symptoms or deal with the underlying problem?.....

Help us monitor changes in your health and well-being and your response to care by completing the following.

DOES YOUR PROBLEM AFFECT…….. (PLEASE TICK ONE FOR EACH SYMPTOM)

	Never	Occasionally	Less than half the time	More than half the time	Constantly
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Bending, Twisting & Lifting	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Freedom of Movement	☐	☐	☐	☐	☐
Housework	☐	☐	☐	☐	☐
Doing Your Job	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐
Relationship (Physical)	☐	☐	☐	☐	☐
Energy Levels	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Breathing	☐	☐	☐	☐	☐
Digestion	☐	☐	☐	☐	☐
Bowel Habits / Regularity	☐	☐	☐	☐	☐
Headaches / Migraines	☐	☐	☐	☐	☐
Recurrent Colds / Illnesses	☐	☐	☐	☐	☐
Water works	☐	☐	☐	☐	☐
Moods / Emotions	☐	☐	☐	☐	☐
Are you in Pain?	☐	☐	☐	☐	☐

Grade your pain (0 is none – 10 is worst) ……

Have you or any member of your family ever suffered from? (please circle & state who)

Dizziness	Allergies / Hayfever	Anxiety / Depression
Trapped Nerves	Backache / Diabetes	Whiplash
Asthma	Heart Trouble / Blood Pressure	Tiredness
Arthritis	Headaches / Migraine	Lack of energy
Sinusitis	Cancer	Acid / Indigestion / Digestive disorders

THANK YOU FOR YOUR ASSISTANCE WITH THESE QUESTIONS

For office:

Very Mild (0-20) Mild (21-40) Moderate (41-66) Severe (67-90) Score…….. /90 NOV 19