

Case No:
Date

MARTINEAU CHIROPRACTIC CLINICS
NEW PATIENTS DETAILS FORM

Surname Title Age.....

Forenames Date of Birth

Address

.....

Home Telephone Work Telephone

Email Mobile

Marital Status Children

Referred by Whom Medical Insurance?: Yes / No

Occupation Employer

Name of GP Telephone No.

Address of GP

.....

Details of any medication currently taken

.....

Details of any serious injuries

.....

Details of any operations

.....

Details of any other recent medical treatment

.....

HeightWeight

Do you smoke ? Yes/No Do you drink? Yes/No No. of Units per week.....

Onset of last menstrual period

Have you or any immediate family members (blood relatives) had any history of these Conditions?

Back/neck pain

Heart/stroke problems

Digestion problems

Bladder problems

Migraine/headaches

Blood pressure problems

Dizziness/vertigo

Cancer

Diabetes

Bowel problems

Arthritis

Multiple sclerosis

Orthopaedic problems

Any other conditions/problems

.....

What is your primary reason for attending this clinic ?

.....

.....

How would you rate your pain level on a scale of 1 to 10? (1= no pain) today
..... worst

It is clinic policy that we write a report to your GP. Do you give consent? Yes / No

To the best of my knowledge I certify that I am / am not pregnant.

PATIENT CONSENT FORM

If under 16 years of age this should be signed by the parent or legal guardian

Name Case

Consent to Examination

I consent to an appropriate physical examination

Signed Date .../.../.....

Consent to X-Ray Examination

I understand the need for an x-ray examination and consent to this procedure.

Signed Date .../.../.....

Consent to Treatment

I have been given an explanation of my condition and the treatment intended. I have been informed about and understand the possible risks of treatment. I have had all my questions answered satisfactorily. I consent to the treatment as explained to me.

Signed Date/...../.....

Data Protection Policy

Under the Data Protection Act 1998 we are required to advise our patients of our Data

Protection Policy. This clinic is required to retain information as part of the patient record for the purpose of consultation for treatment and the recording of treatment given. All Information held will be treated as confidential and will only be released to any other party at the written request of the patient.

I have read this clinics Data Protection Policy and consent to the Chiropractor maintaining records as outlined above.

Signed Date .../.../.....