Patient Health Record

Personal details – Please print carefully and clearly

TITLE	FIRST NAME(S)	SURNAME	DATE OF BIRTH	AGE

Home Address (including postal code)	Phone Number (Home)
	Phone Number (Work)
	Phone Number (Mob)
Marital status	E-mail
Children (Ages, Gender)	Occupation
Date of consultation	Number of Years in Occupation
From whom did you hear about the clinic?	

Health details

GP Name…… Tel…… Address……..

Have you received any treatment or prescription medicines within the last year? YES / NO

If YES please give details ……...……...……

Have you recently **LOST / GAINED** (please circle) weight? **If so…** how much…….…...

Do you smoke? YES / NO how many…..…….. Do you drink alcohol? YES / NO how much?…...……..

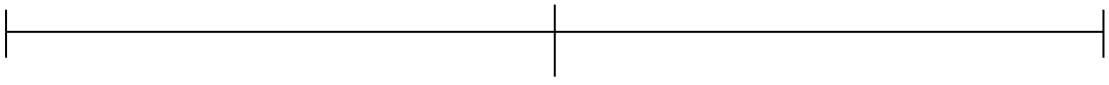
What exercise do you do and how often?……... ……..…….……

Date of last menstrual period ……. Date of last breast screening…….…..

Area of main problem? …….……

Put a cross on the line below to indicate the severity of your complaint so that the left is no problem and right is the most severe problem.

No problem **Very severe problem**



P.T.O

Do you suffer from or have you ever suffered with? (Please circle)

Dizziness	Backache	Heart Trouble/Blood Pressure	Diabetes
Asthma	Arthritis	Headaches/Migraine	Sinusitis
Cancer	Tiredness	Anxiety/Depression	Whiplash
Trapped nerves		Digestive Disorders	

It is the policy of the clinic* that we write to your GP. Do you consent? YES / NO _____(initial)

Do you require a chaperone? YES / NO _____(initial)

Are you covered by health insurance? YES / NO (Please circle) If YES, which one _____

Policy Number: _____ Group Reference: _____ Auth No.: _____

I understand that payment of all fees shall be made by me at the time of each visit, however, if you are claiming the cost of your care back via an insurance policy we have direct arrangements with some insurance companies. In order to do this, we will require an authorisation code and policy number. We will also require your credit/debit card details in case there is any shortfall that may occur. It is advisable to contact the insurance company involved to ascertain details for reimbursement. Failure of an insurance company to reimburse you will not in any way entitle you to a refund from the clinic*. **If I cancel or postpone my appointment with less than 24 hours notice, I agree to pay the full fee as if treatment had occurred**. **I am aware that X-rays are charged additionally to my new patient consultation fee.** Ownership of all x-rays and records will remain the property of the clinic* even when attending the clinic* through a promotional offer. Records may be copied upon written request and will incur a charge of up to £50. Occasionally, it may be necessary to contact me either by post, telephone, or email regarding appointments or other relevant information**. Please be aware that the practitioner providing your care is responsible for your care. Please contact the practice manager in order to view your personal records or to discuss any problems or queries that may occur.

I have read and understand the terms and conditions above and all the information given above is correct to my knowledge *(please sign below).*

Signed ……. Date…….

The clinic* refers to the practitioner that is in charge of your care and the surroundings in which treatment is carried out. Should you have any queries please inform your practitioner that is in charge of your care. This person will be made known to you at the time of initial consultation.

** If you do not want your details entered into our campaign database please make your practitioner aware of this. You can unsubscribe from our email list at any time.