# HOOKWOOD CHIROPRACTIC CLINIC

## Patient Registration Form

Surname_______________________________ Title_______________________________

First Name_______________________________ Initial_______________________________

Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐ Co-Hab ☐

Address_____________________________________________________________

Town/City_____________________________________________________________

County_______________________________ Postcode_______________________________

Home Phone_______________________________ Work Phone_______________________________

Mobile Phone_______________________________ Email_______________________________

Date of Birth_______________________________ Age_______________________________

Medical Insurance Company _____________________________________________

Occupation _____________________________________________________________

GP Name _____________________________________________________________

GP Address _____________________________________________________________

Have you any objection if we contact your GP? Yes ☐ No ☐

Do you want to prevent symptoms from returning? ☐ Or just get out of pain? ☐

**CONFIDENTIAL HEALTH QUESTIONNAIRE**

**Have you ever suffered from any of the following:-**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | ☐ | Depression | ☐ | Heart Disease | ☐ | Pneumonia | ☐ |
| Angina | ☐ | Diabetes | ☐ | Hiatus Hernia | ☐ | Polio | ☐ |
| Appendicitis | ☐ | Eczema | ☐ | HIV | ☐ | Prostate | ☐ |
| Arthritis | ☐ | Epilepsy | ☐ | Jaundice | ☐ | Rheumatic Fever | ☐ |
| Asthma | ☐ | Gall Stones | ☐ | Kidney Stones | ☐ | Stroke | ☐ |
| Blood Pressure | ☐ | Glandular Fever | ☐ | Meningitis | ☐ | Tuberculosis | ☐ |
| Cancer | ☐ | Goitre | ☐ | Pleurisy | ☐ | Ulcers | ☐ |

No of cigarettes/cigars per week:_______________ No of Units of alcohol per week_______________________

Have you ever smoked? Yes No Last menstrual period start date? (if applicable)_________

Please detail any medication you are taking___________________________________________

_____________________________________________________________________

Over the last week, on average how would you rate your major complaint on the scale below?

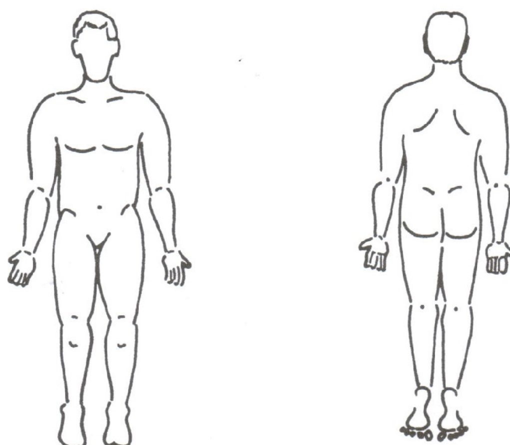
No pain Worse pain possible

0 1 2 3 4 5 6 7 8 9 10

Please indicate on the diagram below where your major complaint is located:

**Legend**

xxx - sharp
||| - dull
ooo - tingling
ΔΔΔ - ache



**PATIENT CONSENT FORM**

- I am the patient / parent / legal guardian (please delete as appropriate)

- I confirm that I consent to physical examination appropriate to my case.

  Signed …………………………………………………………..Date…………………………..

- I consent to my details being stored electronically YES/NO

- I confirm that I have received and understood the information given to me regarding my case. I confirm that I understand the proposed treatment and its implications including the benefits and risks.

  Signed…………………………………………………………...Date…………………………..

- I understand that as the *parent / legal guardian* I must accompany the patient at all times when they consult the clinic and be present in the room at all times

  Signed…………………………………………………………...Date…………………………..