

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 <input type="checkbox"/> | Depression <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Pneumonia <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Hiatus Hernia <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Appendicitis <input type="checkbox"/> | Eczema <input type="checkbox"/> | HIV <input type="checkbox"/> | Prostate <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Gall Stones <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Blood Pressure <input type="checkbox"/> | Glandular Fever <input type="checkbox"/> | Meningitis <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Goitre <input type="checkbox"/> | Pleurisy <input type="checkbox"/> | Ulcers <input type="checkbox"/> |

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) _____

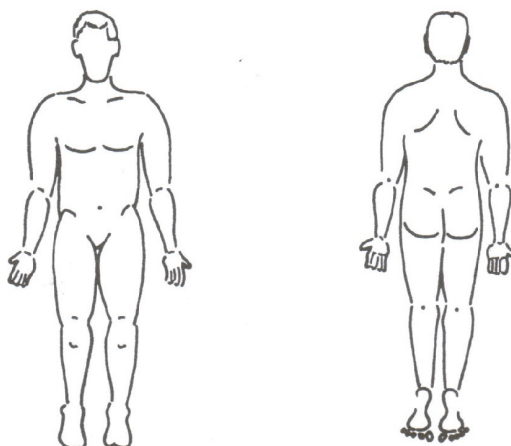
Please detail any medication you are taking _____

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

No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain possible

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

Legend
xxx - sharp
lll - dull
ooo - tingling
ΔΔΔ - ache



PATIENT CONSENT FORM

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

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

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

SignedDate.....

- 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.

- I accept the 24-hour cancellation policy, that any missed appointments or late cancellations may incur a charge.*

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.

- I accept the 24-hour cancellation policy, that any missed appointments or late cancellations may incur a charge.*

Signed.....Date.....