NEW PATIENT FORM

Confidential

PERSONAL DETAILS - Please print clearly

(To be filled in by patient or guardian)

Surname: ______ Title: ______ Age: ______

Forename(s): ______ Date of Birth: ______

Full Address: ______

______ Postcode: ______

Marital Status: ______ Weight: ______ Height: ______

Number of Children: ______ Have you recently lost or gained weight: ______

Mobile: ______ Home Phone No: ______

Email: ______ Work Phone No: ______

Emergency contact: ______ Phone No: ______

Referred by: ______ Newspaper/Mag ☐ Web ☐ Phonebook ☐

EMPLOYMENT DETAILS

Occupation: ______ Employer: ______

Number of years in current job: ______ Previous occupation: ______

HEALTH DETAILS

Name of GP: ______ Telephone No: ______

Surgery Name/Address: ______

Prescribed medication currently taking: ______

______

Non-prescribed medication: ______

Substances you maybe allergic to: ______

Any broken bones (Year/Cause/Outcome): ______

Any Road Traffic or other accidents: (Date) ______

Any Operations/Hospitalisation: ______

Previous imaging (X-rays, MRI etc) + body area: ______ Date: ______

Do you smoke?: ______ per day. Do you drink alcohol?: ______ Units per week

WOMEN :

Last menstrual period started: ______

Are you suffering from:

☐ Cramps ☐ Irregular discharge ☐ PMS

Regular breast examination: Y/N ______

Are you/could you be pregnant: ______

Do you use contraceptives: ______

Are you unable to get pregnant: ______

Last Cervical smear: ______

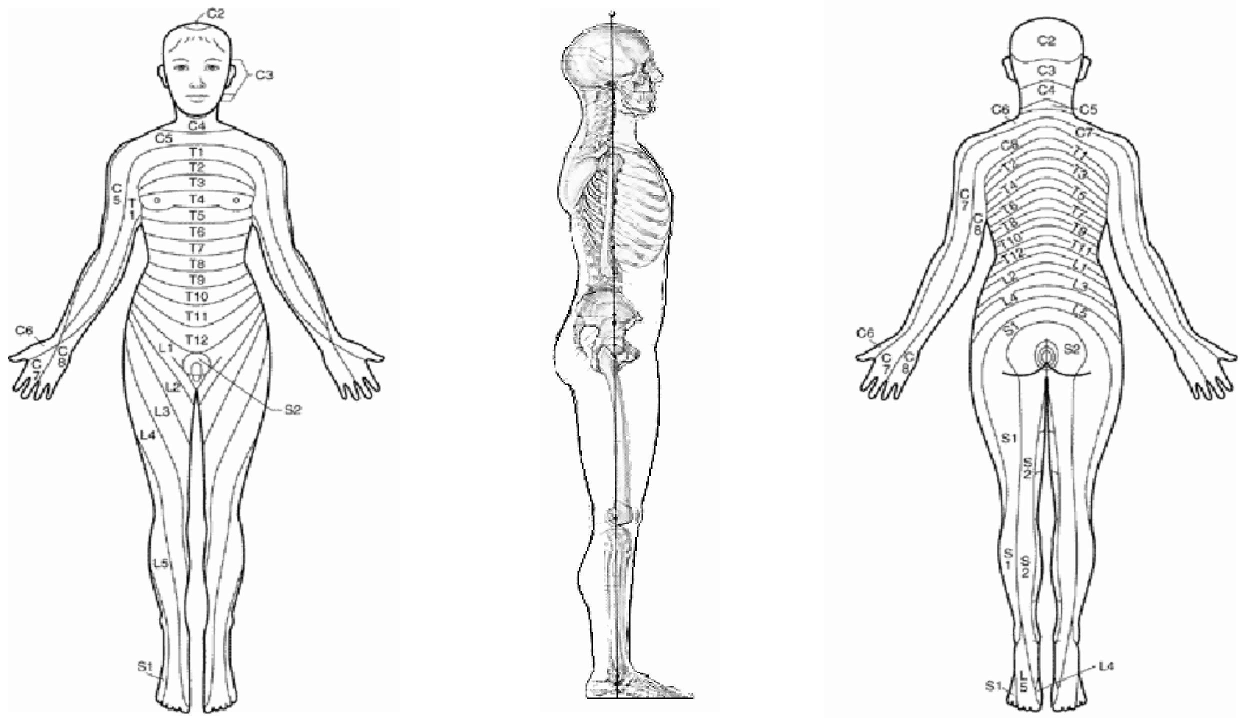
Have you or any family member suffered any of the following?

Tick if applicable		Self	Family member	Year
Liver/kidney problem				
Heart/Stroke Problems				
Lung/Breathing problems				
Digestion problems				
Bowel problems				
Bladder problems				
Reproductive problem				
Circulation problems				
Diabetes				
Cancer				
Epilepsy/nerve disorder				
Allergy and/or skin disorder				
Blood pressure problems				
Migraine/headaches				
Dizziness				
Tinnitus				
Eyes/ear/nose/throat problems				
Arthritis/orthopaedic problems				
Multiple sclerosis				
Psychological problems				
Psychiatric/mental disorders				
Any other problems				

What treatment (s) have you recently undertaken for your chief complaint: (Please detail)

Orthodox Medical
Physiotherapy
Homeopathy
Acupuncture
Chiropractic
Osteopathy
Massage
Other...

Do you have any other health matter/specific questions NOT covered that should be brought to the our attention?



(Please mark on the above figures the location of your pain/discomfort)

MYMOP (Measure Yourself Medical Outcome Profile)

1. Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: ______________________________

0	1	2	3	4	5	6

◄ As good as it could — As bad as it could be ►

SYMPTOM 2: ______________________________

0	1	2	3	4	5	6

◄ As good as it could — As bad as it could be ►

2. Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how it has been in the last week.

ACTIVITY: ______________________________

0	1	2	3	4	5	6

◄ As good as it could — As bad as it could be ►

3. Lastly how would you rate your general feeling of wellbeing during the last week?

0	1	2	3	4	5	6

◄ As good as it could — As bad as it could be ►

4. How long have you had Symptom 1, either all the time or on and off? Please tick box:

0 - 4 weeks ☐ 4 - 12 weeks ☐ 3 months - 1 year ☐ 1 - 5 years ☐ over 5 years ☐

Are you taking any medication FOR THIS PROBLEM Please circle: Yes/No

IF YES:

1. Please write in name of medication (s), and how much:

______________________________ day/week

2. Is cutting down this medication:

Not important ☐ Very important ☐

A bit important ☐ Not applicable ☐

IF NO:

Is avoiding medication for this problem:

Not important ☐

A bit important ☐

Very important ☐

not applicable ☐

INFORMED CONSENT

PLEASE READ and ASK ANY QUESTIONS BEFORE SIGNING

Name: ______________________________

Consent to Physical Examination

I understand that I shall need to answer necessary questions and undergo examination procedures sufficient to determine my suitability for any care the Clinic might recommend. I consent to the Clinic having access to information contained in my medical records and to providing these on request to appropriate third parties who are legally entitled to such information. I consent to an appropriate physical examination.

Consent to Treatment

I understand that I shall be responsible for all associated costs incurred on usual, or specially agreed, terms.
I consent to treatment as outlined to me in pursuit of my primary complaint and to areas associated with it.

✕ Signed: ______________________________ Date: ______________

If you are under 16 years of age, a parent or legal guardian must sign this consent.

Parent/Guardian signature ______________________________ Date: ______________

Data Protection Policy

Under the Data Protection (1998) Act, this Clinic is required to retain information pertaining to consultation and treatments, for a period of 7 years. The confidentiality of all information and records will be strictly observed and will only be released to third parties who are legally entitled according to the Act. All records will be kept securely, either electronically or on paper, for the 7 year period, after which time they will be destroyed.

I, the undersigned (or legal Guardian)* acknowledge that I understand this Policy and agree to it
(* delete as appropriate)

✕ Signed: ______________________________ Date: ______________

If you are under 16 years of age, this consent must be signed by a parent or legal guardian

Parent/Guardian signature ______________________________ Date: ______________