

New Patient Record.

Title: First Name:
Date of Birth / /
Address:

Surname:
Age
Occupation:

Date: / /

Post Code:

Mobile:

Home

Email:

GP.

How did you hear about us?

What is the problem?
(In your own words)

Have you had it before?

What caused it?

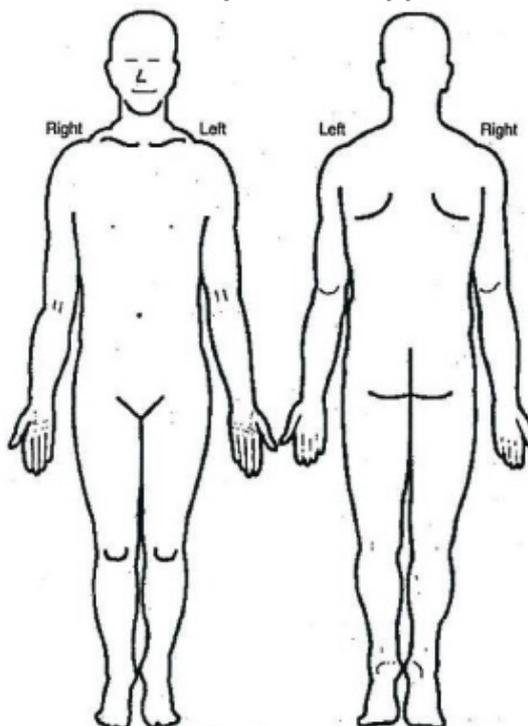
When did it start?

What makes it worse?

What makes it better?

Any previous treatment?

Please mark problem area(s) below



PLEASE TICK ANY CURRENT PROBLEMS / CONDITIONS

Abdominal Pain	Cancer	Eczema	Muscular Tremors
Allergies	Chest Pain	Epilepsy	Nausea
Angina	Chronic Cough	Fainting	Night Sweats
Appetite loss / gain	Circulation	Hay Fever	Prostate
Arthritis	Convulsions	Headaches	Sight / Eye Problems
Asthma	Cramp	Heart Problems	Sleep Problems
Bladder Problems	Depression	Joint Pain	Thyroid
Bowel Problems	Diabetes	Kidney Problems	Any Other
Blood Pressure (high / low)	Dizziness	Liver Problems	
Breathing Problems	Ear / Hearing Problems	Mental Illness	

TERMS OF CONSULTATION

All fees are payable at the time of consultation, any overdue fees may incur an administrative fee.

Please note that you are responsible for all your treatment fees and any insurance excess. Please check your policy.

CANCELLATION

At least 24 hours notice is required if cancelling or changing an appointment or full fee will be charged. Please sign to agree X

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PATIENT INFORMATION

At the Clinic, our aim is to resolve your symptoms quickly and effectively, and treat the cause.

You will be asked about your current problem and any relevant medical history. This may include sensitive questions.

You will be given a full examination of your symptomatic area(s), which will include other areas of your body that we think may be affected.

You may be asked to perform certain movements during your examination; you will also be visually assessed. After the examination you will be given an initial diagnosis. Your problem will be explained to you in simple terms, and a suitable course of action will be discussed with you.

Please wear suitable underwear that will allow us to look at your problems and you feel comfortable being examined in in.

Please be aware that we do not routinely offer chaperones. If you bring a chaperone, they will be very welcome or we can arrange another appointment if required.

If there is any aspect of your treatment you are unsure about, please do not hesitate to ask your practitioner.

I consent to examination and understand that I may withdraw my consent during any part of the examination or treatment process.

I have read, understood and agree to all terms of consultation.

Please sign to agree X.....

WE ARE CONTINUALLY LOOKING AT WAYS WE CAN IMPROVE OUR SERVICE TO YOU, PLEASE CONTACT US WITH ANY SUGGESTIONS THAT YOU FEEL WOULD ENABLE US TO DO THIS.