PERSONAL DETAILS

Surname		Forename	
Title	Age	Date of Birth	
Full Address			Postcode
Marital Status	Number of Children	Age of Children	
Occupation			
What does your job involve? (e.g. sitting, lifting)			
Preferred contact no. (1)		(2)	
Email address			
How did you learn about our clinic? GP / CONSULTANT / GOOGLE / FRIEND / OTHER			
Do you intend to reclaim your fees through health insurance? YES / NO			
If yes, which company?			

HEALTH DETAILS

Name of GP	GP Surgery	
Current Medication		
Significant previous physical or emotional trauma		
Any previous operation/hospitalization (Date/Year)		
Have you consulted your GP about any other medical condition? YES / NO If yes, please give details.		
Have you recently **LOST** / **GAINED** weight? If so how much?		
Previous X-ray / CT / MRI (Date/Year)		
Do you smoke? Y / N	No. per day	How long
Do you drink? Y / N	No. of units per week	
Height	Weight	
Other (non medical) treatments		
Date of last menstrual period	Date of last cervical smear	

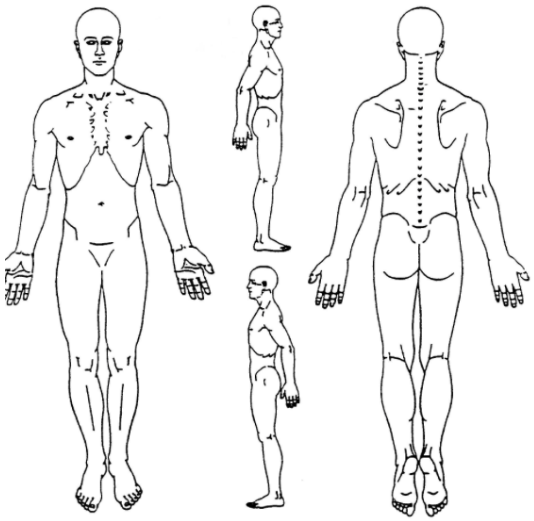
Do you have vertigo or dizziness?	**YES**	**NO**
Do you pass out easily (fainting or loss of consciousness)?	**YES**	**NO**
Do you have double vision or have you lost sight in one eye?	**YES**	**NO**
Do you have any difficulty walking, with coordination, or falling to one side?	**YES**	**NO**
Do you have any nausea or vomiting?	**YES**	**NO**
Do you have numbness on one side of your face or body?	**YES**	**NO**
Do you have any visual disturbances or rapid eye movements?	**YES**	**NO**
Do you have a headache or head pain that is unlike any you have had before?	**YES**	**NO**
Do you have headaches for hours or days?	**YES**	**NO**
Do you have a history of stroke in your family?	**YES**	**NO**
Do you have chest pain?	**YES**	**NO**
Do you have any change in bowel or bladder habits?	**YES**	**NO**
Have you had any episode of loss of bladder or bowel control?	**YES**	**NO**
Do you have any sores that do not heal?	**YES**	**NO**
Do you have any unusual bleeding or discharge?	**YES**	**NO**
Do you have abdominal pain, indigestion or difficulty swallowing?	**YES**	**NO**
Do you have a change in any wart or mole?	**YES**	**NO**
Do you have a nagging cough or hoarseness?	**YES**	**NO**
Do you have night sweats?	**YES**	**NO**
Do you always feel tired?	**YES**	**NO**
Do you have pain in the neck, jaw or face?	**YES**	**NO**
Do you have any ringing in your ears?	**YES**	**NO**
Do you take the oral contraceptive pills?	**YES**	**NO**
Does your pain wake you from a sound sleep?	**YES**	**NO**
Are you coughing up blood or noticing it in your stools or urine?	**YES**	**NO**

Hampstead CHIROPRACTIC

Please indicate if **you** or **any family member** either **currently** or **previously** have suffered with any of the following:

Heart disease / Circulatory problems		Anxiety / Depression	
Blood pressure		Mental state	
Chest Pain / Palpitation		Prostate problems	
Stroke		Reproductive system problems	
Cancer		Digestive problems	
Diabetes		Liver or gall bladder problems	
HIV Positive		Eyes / Ears / Nose / Throat	
Thyroid Disease		Migraines / Headaches	
Joints / Arthritis / Scoliosis		Allergy	
Osteoporosis		Fracture	
Operation		Respiratory Problems (difficulty breathing / asthma / etc.)	
Neurological Conditions (MS, epilepsy, Seizure-Convulsions, etc.)		Urinary Tract Problems (kidneys/ bladder/ etc.)	

Please shade the areas of pain you are experiencing:



Put a vertical mark on the ling to indicate your level of pain.

No pain _____ Maximum pain

I confirm that the information given above is true to the best of my knowledge and belief.

Patient's signature ..... Date .....

Please read this form together with the " Your First Visit" Leaflet and if you are in agreement sign below.

Special Offer for the First Visit (40% off)	£54
Follow up Visits	£45
Pre-pay for six treatment sessions	£243

Forms of Payment
Patients are responsible for full payment at the time of service. We accept cash, cheque and credit cards.

Insurance
All professional services are rendered and charged to the patient receiving care. We will supply you with statements, reports or other documents to help you receive reimbursement from a third party.

Special Arrangements
We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship requires an Individual Consideration Contract, please speak to your chiropractor about this.

Data Protection/Privacy Policy:
By requirement of The Chiropractic Act (1994), this clinic is required to maintain and retain a complete record of consultations and treatments. This information is confidential and only released to third parties with a patient's express and written permission. Confidential patient information is only accessible to staff at the clinic with a direct and appropriate need to do so. All material is kept whilst the individual remains a patient of the clinic and, thereafter, for a period of eight years after which it will be securely destroyed. In accordance with the Data protection Act (1998) a patient may request a copy of their patient record at any time and expect this to be suppled within a reasonable timeframe. In accordance with the law, a commensurate charge may be levied. We will never pass on your personal contact information to third parties without prior notice and consent save for the rare circumstance that your personal data is requested by a government agency in relation to, for example, a crime or for reasons of national security. The clinic may contact you from time to time, using contact information provided, to let you know about matters relating to the clinic. You may choose not to receive this information at any time by letting us know.

Questions?
Please ask if you have any questions about this agreement or if your ability to comply with its provisions changes. We are here to help.

Consent
I have read a "My First Visit" leaflet and the above agreement. I hereby give my consent to undergo chiropractic consultation, examination and treatments. I also consent to my personal data being recorded on computer for these purposes.

Patient's signature ..... Date .....

PATIENT NAME _____ DOB_____