SYMMETRY CHIROPRACTIC

NEW PATIENT FORM

Date: __/__/___

Your Contact Details

Your full name: ____

Date of Birth: __/__/____ How old does that make you? ___________

Address:____

____

Postcode:_________________________

Home Tel No: ______________________________

Mobile Tel No:______________________________

Email Address: ______________________________

How do you prefer to be contacted? (Please circle) SMS / Call mobile/ Call home / Email

Your GP & Practice name: ____

Current occupation: ________________________ Previous: ___________________________

Do you have children? If so, please give number and ages:______________________________

How did you hear about us? Please tell us the name of the person if you can, so we can say "thank you." __________________________________

Past Medical History: Have you ever experienced

A road traffic accident?	YES / NO	Undergone any surgery?	YES / NO
Other injuries/ traumas?	YES / NO	Any allergies?	YES / NO
Been in hospital for illness or tests?	YES / NO	Any night pain?	YES / NO
Are you currently taking medication?	YES / NO	Change in weight?	YES / NO
Night Sweats?	YES / NO	Broken any bones?	YES / NO
Recent changes in your bowel/bladder?	YES / NO		

Please circle if you have ever had any of the following:

Heart/Vascular condition   Digestive condition   Lung condition   Bladder condition

Cancer   Diabetes   Stroke   Osteoporosis   Arthritis

Chest Pain   Abdominal Pain   Menstrual/hormonal problems   Anxiety

Depression   Frequent headaches (more than 1/month)   Migraines   Dizziness

Neurological disorders   Other muscle/joint pain   Other

What?____

Do any illnesses run in your family? YES / NO   What?_______________________________

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Current health complaints(s)/ reasons for consulting our office, please list the most severe first:

1. ____________________ How long? ____________
2. ____________________ How long? ____________
3. ____________________ How long? ____________

RIGHT LEFT

FRONT

Mark the ares on your body where you feel the sensations described useing the appropriate symbol.

Please include all areas affected.

Numbness	= = =
Burning	xxx xxx
Pins & needles	000 000
Stabbing/ sharp	/// ///
Ache/ tension	●●● ●●●

LEFT RIGHT

BACK

On a scale of 1-10 how would you rate your primary complaint X at worst O at best ⊗if both the same

No pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Maximum pain

Previous experience of Chiropractic:

Why have you chosen to come now in particular?

How long do you think it will take to resolve this issue?

What are you most interested in improving?

Overall health | Less Pains/Symptoms | Reducing Stress

Being more active | Improving Posture | Better Sleep

Increasing your energy

Please list any other of your desired health goals and the areas of your life/health you are most interested in improving:

____

____

____

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Your Lifestyle

Do you drink alcohol? YES / NO Have you ever smoked? YES/ NO
Do you exercise regularly? YES / NO
Which position do you sleep in? BACK/SIDE/FRONT/OTHER

On a scale of 1-10 how **stressed/anxious** do you currently feel? (0 = not at all, 10=very stressed)
0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 how would you rate **your current energy levels** ? (0 = lethargic, 10=full of energy)
0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 how would you rate the **quality of sleep** you currently get? (0 = not good, 10=very good)
0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 how would you rate **the healthiness of your diet**? (0 = not good, 10=very good)
0 1 2 3 4 5 6 7 8 9 10

Thank you

If the Chiropractor is waiting, please let them know you have finished the form

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Informed Consent to Chiropractic Care

SYMMETRY CHIROPRACTIC

I hereby give my consent to be physically examined by the Chiropractor.
I have been given a full explanation regarding my condition and have had the opportunity to ask questions and been advised of all treatment options available. I have been advised of possible side effects associated with treatment. I consent to chiropractic treatment for my child as outlined to me.
If you desire a medical diagnosis or believe that you may require medical attention you are advised to consult with your GP in addition to the chiropractor, even while chiropractic care continues. The effectiveness of chiropractic care varies between patients and you are free to stop care at any time or seek advice elsewhere. You will be regularly re-assessed throughout your treatment programme to ensure that chiropractic care continues to be appropriate for you.

Healthcare Insurance

Insurance policies are an agreement between the insured person and insurer. I understand that all services rendered to me by Symmetry Chiropractic are charged directly to me and that I am personally responsible for making payment on or before the delivery of services.

Non-attendance without notice

I understand that should I fail to attend a scheduled appointment without prior notice of 24h or as reasonably as possible, that I will be charged for the missed appointment.

Your Data

We are fully compliant with the General Data Protection Regulations and therefore will only process your information in a lawful and transparent manner. This means we will only gather information from you that we need and it will always be available to you free of charge; this information will always be securely stored; this information will always be up to date and we will ask you on a regular basis to update us; we only keep this information for the length of time required by the General Chiropractic Council (8 years) after which your data will be securely deleted and destroyed. [In the case of children, we have to keep their files for a period of 8 years after their 18th birthday]. We will never share your information without your consent.
If you require access to the records we hold about you from 25th May 2018, all you need to do is write to the clinic with your request or email your request to info@symmetrychiropractic.co.uk and ensure that your request is signed and dated. We also need to verify your identity but will phone you to confirm the request prior to the release of any personal information.
Copies of our full Data Protection Policy are available on request and are also on our website symmetrychiropractic.co.uk.

Please sign that you have received sufficient information to consent to begin chiropractic care and consent to be adjusted by any qualified chiropractor at Symmetry Chiropractic.

Patient name (block capitals) ____________________

Signature of Patient or Legal Guardian ____________________

Date ____________________

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