Advanced Spinal Care
The Thames Clinic

# CONFIDENTIAL PATIENT RECORD

## PERSONAL DETAILS

Title: _____ Today's Date (DD/MM/YY): _____

First Name: _____ Last Name: _____

Date of Birth (DD/MM/YY): _____ Age: _____

Address: _____
Street City

_____
County Postal Code

Tel (M): _____ Tel (H): _____ Email: _____

Marital Status: S / M / D / W Number of Children/Age(s): _____

Emergency Name: _____ Number: _____

## EMPLOYMENT DETAILS

Occupation: _____ Tel (W): _____

Is this a work Related Injury: Y / N

## HEALTH DETAILS

Height (cm): _____ Weight (kg): _____

Previous Chiropractic Care: Y / N When: _____

Name of Chiropractor and Clinic: _____

Name of GP: _____ Phone Number: _____

Do you have Health Insurance: Y/ N Does it Cover Chiropractic: Y /N

Health Insurance Company: _____

How did you hear about us: [ ] Patient [ ] Website [ ] Google [ ] Facebook
[ ] Instagram [ ] Sign [ ] Other:_____

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# CONFIDENTIAL HISTORY

Primary Complaint: _____ Onset: _____

Intensity of Pain: 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

Secondary Complaint: _____ Onset: _____

Intensity of Pain: 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

Any Other Complaint: _____ Onset: _____

Intensity of Pain: 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

The pain is worse in the: [ ] morning [ ] midday [ ] evening

Describe the character of the pain (e.g. sharp, dull, etc.): _____

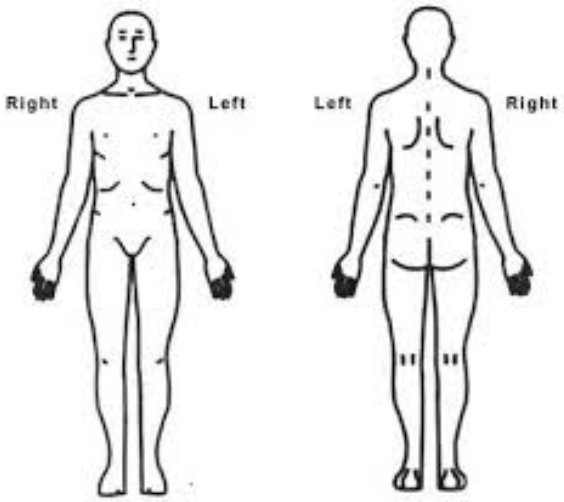
The pain is getting: [ ] better with time [ ] worse with time [ ] the same with time

The pain is: [ ] constant [ ] come and goes

Is the pain spreading? Y / N If yes, where: _____

Suffer from headaches? Y/ N If yes, for how long: _____

Please mark the areas affected on the diagram:




What relieves your symptoms: _____

What aggravates your symptoms: _____

The pain interferes with: [ ] home [ ] work [ ] leisure

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Has your condition been treated in the past: Y / N When and by whom: _____

Your expectations for treatment: [ ] pain relief [ ] spine/posture correction [ ] optimize health

List any injuries/traumas/accidents/fractures:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any surgeries and hospitalizations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any medication:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family medical history: _____

Please rate your stress level (0=no stress 10=extreme stress): 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

Do you sleep on your: [ ] Back [ ] Side [ ] Stomach Number of pillows: _____

How many hours do you sleep each night: _____ If less than 7 hours, why: _____

Physical activities or sports: Y / N
If yes, which activities/sports: _____

How much water do you drink/day: _____ How many cups of tea or coffee/day: _____

Do you smoke: Y / N If yes, how many cigarettes/ day: _____

Do you drink alcohol: Y / N If yes, how many units/week: _____

FOR WOMEN: Is there any possibility that you might be pregnant: Y / N If yes, weeks: _____

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Please check off any physical ailments you are experiencing/have experienced in the past:

| | | | |
|---|---|---|---|
| [ ] cancer | [ ] night pain/sweats | [ ] high blood pressure | [ ] heart attack |
| [ ] high cholesterol | [ ] stroke | [ ] heartburn | [ ] breathing difficulties |
| [ ] asthma | [ ] diabetes | [ ] fatigue | [ ] anxiety |
| [ ] depression | [ ] tremors | [ ] ringing in the ears | [ ] hearing loss |
| [ ] dizziness/vertigo | [ ] osteoporosis | [ ] arthritis | [ ] sleeping disorders |
| [ ] joint stiffness | [ ] scoliosis | [ ] digestive disorders | [ ] weight gain/loss |
| [ ] vision disorders | [ ] skin problems | [ ] urinary disorders | [ ] fever/chills |
| [ ] sexual dysfunction | [ ] epilepsy | [ ] ear infections | [ ] loss smell/taste |
| [ ] allergies | [ ] thyroid disorder | [ ] prostate disorder | [ ] sinus problems |
| [ ] frequent cold/flu | [ ] eating disorder | | |

[ ] other:_____

I, _____ declare that I have provided all the information requested to the best of my knowledge, and now consent to a physical examination.

Signature: _____ Date: _____

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# INFORMED CONSENT TO CHIROPRACTIC CARE

There are many concerns about the safety of procedures we undergo routinely, the environment that we live in and the food that we consume to name but a few. I hope to explain some of the risks and common responses to chiropractic care so that your concerns may be eased and that you have a better understanding of the adjustments you will be receiving.

Most people will experience some level of discomfort in the early stages of care. This is due to the body settling down and adjusting to new mechanical patterns of movement. It is quite a normal response during the initial stages of care.

If you are (or have been) taking any anti-coagulant (blood thinning) or steroid based medication, then it is important to tell your chiropractor before care commences. It is also prudent to inform them of any other any other medication you may currently or have previously been taking.

In extremely rare circumstances, chiropractic care of the neck may damage blood vessels and give rise to stroke or stroke like symptoms (less than 1 in 2,150, 000). To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for your aches and pains is 3 in 1000 or 7 in 1000 of dying during surgery.

Chiropractic adjustments of the spine are internationally recognized as being far safer in dealing with neck and low back pain than medication and many other alternatives.

We must explain these risks to you so that you can make an informed decision about beginning or continuing your care. If you have any further worries or questions, please feel free to ask your chiropractor.

The adjustments and care you receive will be tailored to you and your specific health needs. If at any stage of care, you are uncomfortable, have doubts or questions then please express them to your chiropractor. Our technique of adjustment can be adapted to suit almost any person, age or condition.

In the case when your usual chiropractor is away, the continuity of your care will be maintained by a registered locum chiropractor.

The clinic operates a 24-hour cancellation policy and has the right to charge any cancelled or missed appointment at this short notice.

I have read and understood the above information and discussed any concerns I may have with the chiropractor. I have been given a report of findings and treatment plan regarding my condition and give my consent to chiropractic care.

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (if under 18) Chiropractor's Signature

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# DATA PROTECTION POLICY

Under GDPR, we are required to advise our patient(s) on our Data Protection Policy.

The Thames Clinic is fully compliant with all the regulations and legal requirements of the Data Protection laws in the UK. We 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; 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 will keep this information indefinitely unless you request, in writing, to delete and destroy this information 8 years after the date of your last visit; this is the length of time required to hold your records (personal details, medical notes and electronic images) by the General Chiropractic Council (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. You can withdraw your consent at any time.

If you require access to the records we hold about you, all you need to do is write to the Clinic with your request or email your request to info@thethamesclinic.com 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 release of any personal information.

Copies of our full Data Protection Policy are available on request in the clinic and on our website: www.thethamesclinic.com

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I, _____ give consent to the use and disclosure of my personal health records by The Thames Clinic to other primary health care providers, if required.

Please confirm that you are happy for us to send you an appointment confirmation via email at the time of booking and an SMS text 2 hours before your appointment time. Please Tick:

[ ] Yes, I would like an email & text reminder
[ ] No, I do not need an email or text reminder

Please note that we will not email or contact you for marketing purposes without your specific consent. Please Tick:

[ ] Yes, I would like you to keep in touch with promotions, clinic updates & special events
[ ] No, I do not wish to be contacted about promotions, clinic updates & special events

I, the undersigned (or undersigned Guardian), acknowledge that I have read and understood the information above and do hereby give my consent

Signature: _____ Date: _____