

## CONFIDENTIAL PATIENT RECORD

### PERSONAL DETAILS

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (DD/MM/YY): \_\_\_\_\_ Age: \_\_\_\_\_ Car Reg: \_\_\_\_\_

Full Address with Post 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: \_\_\_\_\_ Tel: \_\_\_\_\_

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  Other Social Media

Other \_\_\_\_\_  Fair \_\_\_\_\_

**CONFIDENTIAL HISTORY**

Primary Complaint: \_\_\_\_\_ Onset: \_\_\_\_\_

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

Any Other Complaint: \_\_\_\_\_

The pain is worse in the:  morning  midday  evening

Describe the character of the pain (eg. sharp, dull, etc.) \_\_\_\_\_

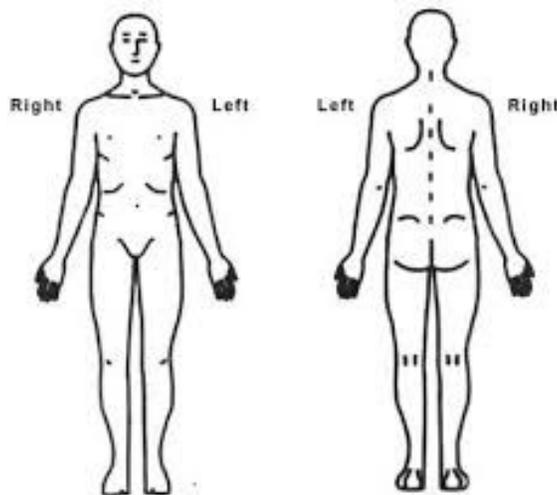
The pain is getting:  better with time  worse with time  the same with time

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

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

Goals/expectations for treatment: \_\_\_\_\_

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: \_\_\_\_\_

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

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

I hereby give my informed consent to undergo a physical examination as explained to me by my Chiropractor. The risks, benefits and alternatives have been explained to me, including that some examinations may temporarily elicit discomfort or pain as part of the examination process. I have been given an opportunity to ask any questions and they have been answered satisfactorily regarding the examination and I wish to proceed with the examination.

I have been offered a chaperone and been given the opportunity to consider this

I consent to the examination and do NOT require a chaperone during the appointment.

I consent to the examination and will be providing my own chaperone during the appointment.

It has been explained to me that a gown and a private place to change is available to me. I confirm that:

I have been offered a gown and I have chosen to wear one.

I have been offered a gown and I have chosen NOT to wear one.

Patient Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



## 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](mailto: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](http://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: \_\_\_\_\_

## What to Expect at Your First Visit

Thank you for choosing The Thames Clinic. Your first visit is designed to help us understand you, your health, and how best we can help.

- Before anything takes place, your chiropractor will review the information you've provided and may ask further questions to understand your health history and current concerns. You'll always have an opportunity to ask questions at any stage of your journey with us.
- If it is appropriate to continue, the chiropractor will explain whether a physical examination is recommended and what it will involve. Examples of examination procedures may include orthopaedic and neurological tests, digital posture analysis and spinal assessments. You'll have time to ask questions before any part of the examination begins.
- Some parts of an examination may require the removal of clothing so that your chiropractor can assess posture or particular regions of the body. A gown and a private changing space will always be offered to maintain your comfort and dignity.
- The clinic has its own in-house plain film x-ray facility. If images are clinically indicated, the chiropractor will explain why and the cost involved. If any other diagnostic tests are advised (for example an MRI) your chiropractor can refer you to another facility. Any hospitals or imaging centres we refer to have their own fees; we do not add any additional charges for referrals.
- At the end of the appointment, your chiropractor will advise when to return for your Report of Findings appointment. At this visit, your personalised care recommendations will be outlined.
- Adjustments are only given when it is appropriate and safe to do so. Your chiropractor will explain their findings and any recommended care before anything takes place. It is not routine to receive an adjustment on the first visit, as we first need to review your health history and examination results. You will have time to consider any recommendations. If you feel ready to begin care sooner, you can choose to do so.
- If you would like a chaperone, you are welcome to bring someone with you.
- Your information will be treated confidentially and stored in accordance with our Patient Privacy Policy.
- At times, other individuals (such as staff, trainees) may be present in the practice. If you would prefer your consultation or examination to be private, please tell us and we will ensure privacy.
- All our chiropractors are registered and regulated by the General Chiropractic Council (GCC). In the case when your usual chiropractor is away, the continuity of your care will be maintained by a registered GCC chiropractor.
- Our Terms of Business, including fees, payment, late cancellations, refunds, missed appointments and complaints procedures are available at reception.
- The clinic operates a 24-hour cancellation policy and has the right to charge any cancelled or missed appointment with less than 24 hours' notice given.

I confirm that I have completed this health form accurately and to the best of my knowledge. I have read and understood the information above and I am aware that my chiropractor will explain what will happen during my first appointment.

Patient Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_