Case No: ……………
Date ……………..

MARTINEAU CHIROPRACTIC CLINICS
NEW PATIENTS DETAILS FORM

Surname ……………………….. Title ………… Age…………

Forenames ………………………. Date of Birth ……………….

Address ……………………………………………………………….

……………………………………………………………………………….

Home Telephone ………………….. Work Telephone ………….

Email …………………… Mobile …………………….

Marital Status …………………… Children ……………………

Referred by Whom ………………. Medical Insurance?: Yes / No

Occupation ………………………. Employer …………………

Name of GP ………………………. Telephone No. …………….

Address of GP ……………………………………………………….
………………………………………………………………………………….

Details of any medication currently taken …………………………..
………………………………………………………………………………….

Details of any serious injuries ………………………………………….

………………………………………………………………………………….

Details of any operations ………………………………………………..

………………………………………………………………………………….

Details of any other recent medical treatment ………………………

………………………………………………………………………………….

Height ………………………………Weight ……………………..

Do you smoke ? Yes/No Do you drink? Yes/No No. of Units per week………

Onset of last menstrual period
Have you or any immediate family members (blood relatives) had any history of these Conditions?

Back/neck pain ……………………………………………………………………………

Heart/stroke problems ……………………………………………………………………

Digestion problems ………………………………………………………………………

Bladder problems …………………………………………………………………………

Migraine/headaches ………………………………………………………………………

Blood pressure problems …………………………………………………………………

Dizziness/vertigo …………………………………………………………………………

Cancer ……………………………………………………………………………………

Diabetes …………………………………………………………………………………

Bowel problems …………………………………………………………………………

Arthritis …………………………………………………………………………………

Multiple sclerosis …………………………………………………………………………

Orthopaedic problems ……………………………………………………………………

Any other conditions/problems ……………………………………………………………

……………………………………………………………………………………………

What is your primary reason for attending this clinic ? ………………………………….

……………………………………………………………………………………………

……………………………………………………………………………………………

How would you rate your pain level on a scale of 1 to 10? (1= no pain) …… today
…… worst

It is clinic policy that we write a report to your GP. Do you give consent? Yes / No

To the best of my knowledge I certify that I am / am not pregnant.

PATIENT CONSENT FORM

If under 16 years of age this should be signed by the parent or legal guardian

Name …………………………………........................ Case ……………………………

Consent to Examination

I consent to an appropriate physical examination

Signed …………………………………......................... Date …./…./…..

Consent to X-Ray Examination

I understand the need for an x-ray examination and consent to this procedure.

Signed …………………………………......................... Date …./…./…..

Consent to Treatment

I have been given an explanation of my condition and the treatment intended. I have been informed about and understand the possible risks of treatment. I have had all my questions answered satisfactorily. I consent to the treatment as explained to me.

Signed …………………………………................................ Date …../…../…..

Data Protection Policy

Under the Data Protection Act 1998 we are required to advise our patients of our Data

Protection Policy. This clinic is required to retain information as part of the patient record for the purpose of consultation for treatment and the recording of treatment given. All Information held will be treated as confidential and will only be released to any other party at the written request of the patient.

I have read this clinics Data Protection Policy and consent to the Chiropractor maintaining records as outlined above.

Signed ………………………………................................... Date …./…../…….