Wellness & Vitality Chiropractic
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Welcome to Wellness & Vitality Chiropractic!

The purpose of this practice is to help people get well and stay well.

Personal Information – Please PRINT.

Full Name:	Date:
How do you wish to be addressed?	
Address: Postcode:	
Home phone:	Work phone:
Mobile phone:	Email address:
Best time/place to contact you:	
Date of birth:	Age:
No of children: What are their ages?	Pregnant? Yes No
Marital status: M S W D CP	Occupation:
Our policy is that we do not invoice Insurance Companies on your behalf, but we are very happy to provide you with a receipt if it is required.	
I understand that I am liable for fees incurred and that payment is at the time of service. Signed:	
GP:	Surgery Address:
From time to time it may be necessary to contact your doctor to discuss your progress. This will not be done without your knowledge. Do we have your consent to do this? Yes No	
Who may we thank for referring you?	

What is the main reason for coming today?_____

Have you seen anyone regarding this complaint? Yes ☐ No ☐

Whom?_____

Was it helpful? Yes ☐ No ☐

Please list **ANY** medications you are currently taking:_____

_____

_____

Please list **ANY** surgery you have had and when_____

_____

Have you had any of the following? If yes, describe briefly (e.g. dates, hospitalised, treatment, etc).

- Vehicle accident_____
- Broken or dislocated bones?_____
- Falls or knocks (accidental or sports related) _____

  _____

Have you had any x-rays or scans of your spine? Yes ☐ No ☐

If so, what area and when?_____

Do you have any conditions you have been told to "live with"? Yes ☐ No ☐

What?_____

Is there any family history of illness? Yes ☐ No ☐

What?_____

_____

_____

People come to see us for myriad reasons so it is very important to us at "Wellness & V*i*tality Chiropractic", that you understand how we can help and what we do and don't do.

Whilst Chiropractic is very good at alleviating pain and symptoms, it does not "cure" anything. The only person that can cure you, is you. You are self healing and self regulating. This happens through your nervous system which connects your brain to your body. The better connected your nervous system, the better your body will function. Chiropractors work on your spine to remove interference from your nervous system. Diet and exercise are also essential ingredients to a healthy body and mind.

What are your goals in coming to Wellness & Vitality Chiropractic?

☐ **Relief of symptoms only:** Generally this is a short intensive course of treatment. 3-12 weeks depending on your history.

☐ **Rehabilitation:** This is a moderate term of care aimed at improving your symptoms and then allowing the body to heal more effectively by supporting proper function with the addition of strengthening exercises.

☐ **Maintenance:** Rehabilitation care followed by regular checks to reduce the chance of the reoccurrence of symptoms.

☐ **Wellness:** Regular checks, regardless of symptoms, in order to facilitate better neurological function and thus improve the innate healing abilities of the body. This also includes taking responsibility for lifestyle choices such as diet, rest and exercise.

CONSENT FORM

I_____ (Name) consent to an appropriate physical examination and understand that this, in conjunction with my history, is necessary for the Chiropractor to more fully understand if I am a suitable candidate for Chiropractic care.

I understand that there are risks associated with all forms of therapeutic intervention but that the risk of permanent injury or death associated with manual spinal adjustment is extremely low (approximately 1 in 2,500,000). I understand that the Chiropractors at "Wellness & V*i*tality Chiropractic" choose to utilise lower force techniques whenever possible to reduce this risk even further. I have had my concerns and questions addressed to my satisfaction and have read and understood the practice policies, and do hereby consent to treatment.

Signed:_____ Date:_____/_____/_____

If you are under 16 years of age, this consent should be signed by a parent or legal guardian.

Signed:_____(Parent/Guardian) Date:_____/_____/_____

DATA PROTECTION POLICY

Under the Data protection (1998) Act, we are required to advise our patient(s) on our Data Protection Policy.

As part of the Patient Record, this clinic is required to retain information for the purpose of consultation for the treatment, recording subsequent treatments, and for the use by third party medical practitioners only, at the request of the patient, in writing.

Upon completion of the Patient Details Form, Data protection and consent form, all paper files and information therein may be electronically scanned and stored on computer file for as long as the patient remains a patient of the Clinic, and thereafter for a period of 8 years. Alternatively paper records will be retained for the same period.

All information provided will be treated as confidential, and will not be given to any other person(s)/ organisation(s) without the written consent of the patient concerned.

Information will be held both manually and electronically in files accessible only by staff of the Clinic who are directly involved in the data entry and processing of patient records.

You have the right of access to the data we hold about you and to receive a copy. Access may be obtained by making a request in writing and the payment of a fee of up to £10. We will provide a copy of the record within 30 days of the request and fee (where payable).

I the undersigned (or authorised Guardian)** acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the Practitioner/Chiropractor to maintain records for the purposes outlined within the policy.

Patient:_____(Print Name)

Patient:_____(Signature)

Date _____/_____/_____

** For patients under the age of 16, a Parent/Guardian is required to sign.

Consent to Leave Messages

In accordance with the Data Protection Act, Wellness & Vitality Chiropractic requires written consent from any patient who is happy for us to leave a message on their answer phone in the event that we need to contact them. If we do not have written consent, we are unable to leave a message on any answer phone or with a third party.

PLEASE COMPLETE THE FOLLOWING:

I give consent for the practice to leave messages on my answer phone or with a third party (please print third party name):

Name: _____

Home: _____Mobile: _____

Work: _____

On occasion we may like to make you aware of events or information that we feel may be of interest to you via email.

Please tick if you would like to receive this information ☐

The consent is to remain in force from today until further notice of cancellation by me.

Signed: _____

Print Name: _____

Date: _____