PATIENT HEALTH RECORD - CONFIDENTIAL

PATIENT TO COMPLETE – please read and complete all sections.

Date:
Mr/Mrs/Miss/Ms/Other: First name: Surname:
Address (in full): Home tel: Sex: M/F
Work tel: DOB:
Mobile: Age:
Email: Height:
Postcode: Weight:
No of children: Ages of children:

In accordance with the Department of Health's Best Practice Guidance under race Relations (Amendment) Act 2000 we monitor ethnicity.

What is your ethnic group? Choose ONE section from A to E, and then tick the appropriate box to indicate your ethnic group.

A: White British Irish any other white background – please write in.
B: Mixed White and Black Caribbean White and Black African White and Asian Any other mixed background - please write in.
C: Asian or Asian British Indian Pakistani Bangladeshi Any other Asian background –please write in.
D: Black or Black British Caribbean African Any other Black background – please write in.
E: Chinese or other ethnic group Chinese Any other - please write in
Not stated

Occupation: Number of years in job:
Previous occupation if less than 2 years in current occupation:

How did you hear about us? Recommendation Internet Yellow Pages Walk Past
Other - please specify.
Name of GP: Insurance company:
Address of GP: Policy/Claim number:

Do you consent to us informing your GP regarding your treatment? Yes No
Do you consent to us contacting you by (delete as appropriate) Mail Email Text Message

Please list:

Any medication currently being taken: Any major falls or injuries:

Any road traffic accidents: Any broken bones:

Please list ALL surgical procedures and dates:

Any ongoing health problems? Any major disease past or present?

Have you had any x-rays or scans? Yes No If YES, of what and when:
Have you had any other investigations? Yes No If YES, of what and when

Do you smoke? Yes No Number of cigarettes per day:
Have you ever smoked? Yes No If YES, for how long and when did you stop:
Do you drink alcohol? Yes No Number of units per week:
(1/2 pint, small glass wine, single spirit measure)
Do you drink caffeine drinks? Yes No Number of cups per day (coffee, tea, cola, energy drinks)

Have you received any other medical treatment recently? Yes No
If YES, please describe.

Reason for consulting this clinic: (please tick box below)
Pain/symptom relief Correction of the underlying cause of the problem
Achieve optimum health and wellbeing

How much water do you drink per day?

Do you currently take any supplements/vitamins/minerals? Yes No
If YES, please list which ones:

Do you play sports/have you any hobbies? Yes No
Please specify:

How would you rate your health generally?

I've never felt worse 1 2 3 4 5 6 7 8 9 10 feel great

Is there any other information you feel you need to discuss with your osteopath:

WOMEN ONLY:
Last breast examination:
Last menstrual period started:
Is there any chance you may be pregnant? Yes No
Are you trying for a baby? Yes No

MEN ONLY:
Have you had a prostate examination? Yes No If YES, when was your last examination?

Have you or any of your family members (siblings, parents and grandparents) **suffered with any of the following:**

	Self (please specify problem)	**Immediate family** (please specify relation and problem)	**Year**
Spinal problems:			
Liver/kidney problems:			
Heart disease/stroke:			
Lung/breathing problems:			
Digestion problems:			
Bowel problems:			
Bladder problems:			
Reproductive problems:			
Circulation problems:			
Diabetes:			
Cancer:			
Epilespy/nervous disorders			
Allergy/skin disorders			
Blood pressure problems:			
Migraine/headaches:			
Dizziness:			
Tinnitus (buzzing in ears):			
Eyes/ears/nose/throat problems:			
Multiple sclerosis:			
Any other problems:			

Please describe your primary complaint: i.e. back pain, neck pain, etc.

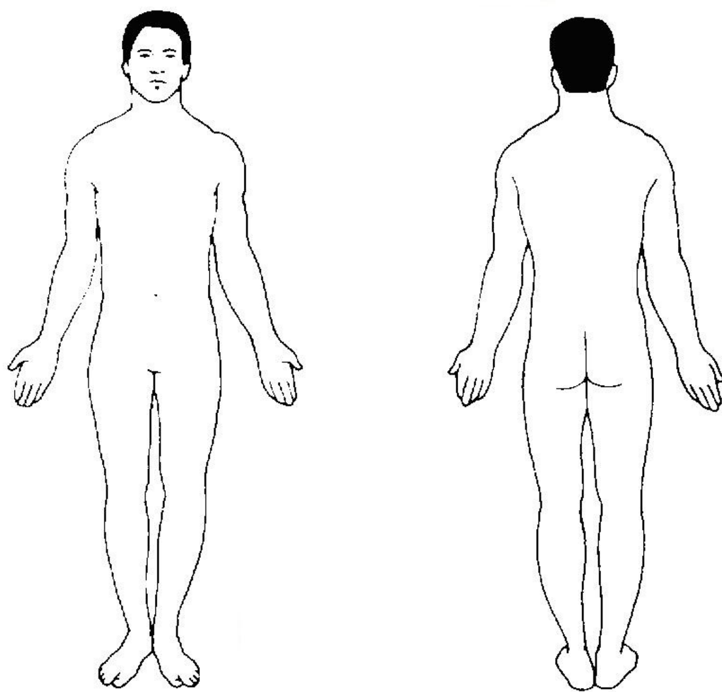
Please indicate on the scale below what your pain level is when you feel at your worst
No pain 1 2 3 4 5 6 7 8 9 10 Maximum pain

Please indicate on the scale below what your pain level is when you feel at your best
No pain 1 2 3 4 5 6 7 8 9 10 Maximum pain

Please describe any other complaints:

Please indicate on the scale below what your pain level is when you feel at your worst
No pain 1 2 3 4 5 6 7 8 9 10 Maximum pain
Please indicate on the scale below what your pain level is when you feel at your best
No pain 1 2 3 4 5 6 7 8 9 10 Maximum pain

Please indicate area(s) of complaint as per key:



NUMBNESS

SEVERE PAIN

MODERATE PAIN

SHOOTING PAIN

CONSENT TO CONSULTATION AND EXAMINATION

I understand that the osteopath will explore my case history and conduct a physical examination. I understand that examination may require me to disrobe as appropriate, and that towels/gowns will be provided to maintain my comfort/modesty.

I understand that before treatment is received that I shall be required to give a specific consent to this.

Before agreeing to treatment I shall receive:

- an explanation of my problem(s),
- the osteopaths prognosis (the likely outcome),
- an explanation of the treatment and the techniques which will be used.
- an explanation of the relative risk of these procedures.

I consent to an appropriate consultation and examination by an osteopath at this clinic. The information I provide will, to the best of my knowledge, be as accurate and truthful as possible. I understand that I am able to withdraw consent at any time if I feel at all uncomfortable with the consultation/examination.

I understand that I may request that a chaperone attend.

I do/ do not require a chaperone to be present. (delete as appropriate)

Chaperone name and relationship to patient: (print name as necessary)

…………………………………………………………………………………………………...

Signed: (parent or guardian if under 16) **Print name:**
Date:

TERMS AND CONDITIONS

Please read and sign the terms and conditions detailed below:

Walthamstow Osteopaths Ltd reserves the right to charge a full fee for any appointment which is not kept or cancelled with less than 24 hours notice.

If payment is through an insurance company, it is the patients' responsibility to provide payment should funds not be forthcoming from the insurance company for any reason.

All information provided by the patient will be treated confidentially and will be appropriately protected. Walthamstow Osteopaths Ltd is compliant with the Data protection Act.

We aim to provide an effective and professional service to our patients. If however you have any comments on our service please direct these to the Practice Coordinator. Should it be necessary we have a formal complaints procedure, details of which are available from the Practice Coordinator.

Signed: **Date:**

OSTEOPATH TO COMPLETE

Primary presenting problem: Secondary problem:

Treatment given: Osteopaths name:

Entered on database: Man / Sed

CONSENT TO OSTEOPATHIC CARE

Please read this page but do not sign until you have discussed the contents with the osteopath.

Name of osteopath:

Osteopathic treatment is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, which you should be informed about. I am obliged to advise you of any inherent risks associated with the particular treatment including any low risks of serious debilitating outcomes.

Please read the following carefully:

1. I acknowledge that I have discussed with the osteopath the possible reactions to osteopathic treatment which include (although not limited to) muscle and joint soreness, and a short-term exacerbation and/or aggravation of my underlying condition.
2. I acknowledge that I have discussed with the osteopath the risks associated with the proposed treatment which include fractures, disc injuries, and stroke (or like episodes). I understand that the risk of such injuries is remote and that the osteopath has taken a medical history performed a thorough examination to exclude any reasons why specific treatment techniques should not be used.
3. I also acknowledge the following potential risks insofar as my proposed care is concerned have been explained to me:
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
4. I have had the opportunity to discuss the proposed care with the above named osteopath. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed osteopathic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed osteopathic care by the osteopath and/or any other osteopath working in this clinic. I understand that I can withdraw my consent at any time.
7. I have been told and advised of my right to have a chaperone and that I may have to disrobe to my underwear to enable the better treatment of my condition.

………………………………………………………………..
Patient's signature (parent or guardian if under 16)

…………………………………………
Patient's name (printed)

………………………
Date