TOLL HOUSE CLINIC Ltd

TOLL HOUSE CLINIC PATIENT DATA AND CONSENT FORM

Title:	First Name:	Surname:
Address: Postcode:		
Date of Birth:	Email:	
Tel/Mob:	Tel/Home:	
Occupation:	Hobbies / Sports:	
GP Surgery:	Referral Source: GP ☐ Consultant ☐ Insurance ☐ Self ☐	

Insurance Details: Not Applicable: ☐
Insurance Company:
Policy Number: Authorisation Number:
Number of Sessions Authorised: Excess Amount:

Area of Treatment:

Neck	☐	Upper Back	☐	Lower Back	☐
Hip	☐	Knee	☐	Ankle / Foot	☐
Shoulder	☐	Elbow	☐	Wrist / Hand	☐
Whole Body	☐				

Duration of problem ……………………………… Days / Weeks / Months / Years

If in pain, please indicate on this scale: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Consent: We are committed to protecting the privacy of our patients. **Please read our Toll House Clinic Privacy Policy 2018** before signing the consent below, this will give you exact details of how we store and protect your data, according to current GDPR legislation May2018.

I consent to treatment at Toll House Clinic which may include:

Physiotherapy	Chiropractic	Manipulation
Massage	Reflexology	Podiatry/Chiropody
Pilates	Yoga	Acupuncture

YES/NO

You have rights under the access to MRA act 1988 to view your medical notes.

I consent to personal and medical details being stored in accordance to Toll House Clinic Privacy policy: **YES/NO**

I consent to a medical report being supplied to ;

My GP/ Consultant **YES/NO** My employer **YES/NO** My insurer **YES/NO**

Contact preferences

I consent to being contacted for appointment booking confirmation and follow up by;

Phone **YES/NO**

Email **YES/NO**

Letter **YES/NO**

I consent to being contacted for newsletters/marketing/special offer by e mail: **YES/NO**

Your details will not be shared with any third party for marketing purposes.

You may amend or withdraw your consent at any time.

Signed ……………………………………… Date…………………

Printed name: …………………………………

PLEASE TURN OVER

Medical Questionnaire

Questions	Yes / No N/A	Comments
Are you on any medication (or have been in the last 6 months)? Please List		
Are you taking Steroids? (or have in the last 2 years)		
Have you ever had Rheumatic Fever?		
Are you expecting a baby, or breastfeeding?		
Have you ever had Hepatitis?		
Have you ever had trouble with Heart / Chest /wear a pacemaker?		
Do you suffer from any allergies?		
Do you suffer from any blood disorders?		
Do you have fainting attacks or blackouts? High or low blood pressure? dizziness?		
Do you have Diabetes?		
Have you had any surgery, or been in hospital for anything?		
Do you suffer from epilepsy?		
Are you Asthmatic?		
Do you suffer from Osteoporosis?		
Do you have Rheumatoid Arthritis?		
Do you have Osteoarthritis?		
Do you have a thyroid disorder?		
Do you suffer from headaches regularly?		
Have you suffered from a whiplash injury in the last 5 years?		
Do you have any skin conditions or complaints?		
Do you have any balance issues?		
Do you need a downstairs room?		
Do you need assistance with mobility?		
Are there any other medical details about you, that we should know?		
Have you had previous treatment?		
Have you had an x-ray/scan of the area? If so when and where?		

This questionnaire is for your safety, thank you for answering the questions.
The responsibility for joining an exercise class lies with the participant.