**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 May 2018.

I consent to treatment at Toll House Clinic which may include the following: **YES/NO**

Physiotherapy Chiropractic Manipulation

Massage Reflexology Podiatry/Chiropody

Pilates Yoga Acupuncture

I confirm I have not had any Covid 19 symptoms within the last 5 days **YES / NO**

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

I consent to My sensitive Data 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 / Email / 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.

**Fees:** I consent to liability for full payment of fees if unpaid by my health insurance Provider.

I understand there is a 24 hour cancellation notice period, missed appointments will be subject to a charge.

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

Printed name: **PLEASE TURN OVER**

**Medical Questionnaire**

|  |  |  |
| --- | --- | --- |
| This questionnaire is for your safety, thank you for answering the questions. | **Yes/No** | **Please give details** |
| 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? |  |  |
| If female, are you pregnant/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? |  |  |
| 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? Ie. Stroke, Heart Attack, TIA |  |  |
| Have you had previous treatment? |  |  |
| Have you had an x-ray/scan of the area? If so when and where? |  |  |
| Are you considered vulnerable or immunosuppressed or receiving cancer treatment? |  |  |

**Name: Signed: Date:**