Candlewell Clinic

Personal Details			
Owner's Name:			
Pet's Name:			
Address:			
	Post code:		
E-mail:			
Contact Numbers:			
Home: Mobile:			
Work: Other:			
New Patient Questionnaire; Animals			
VET DETAILS			
Has your vet authorised your visit?		Yes	No
Vet's Name:			
Surgery:			
Surgery Address:			
E-mail:			
Contact Number:			
YOUR PET'S DETAILS			
Dog Cat Other:			
Age:			
Breed:			
Sex:			
D.O.B.:			
Length of ownership:			
Do you own other animals?			

e the website "Terms & Conditions" for how we control your personal primation or ask to see a copy in our clinic. What do you think is your Pet's problem? What started it off? Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the lesignation letter in the boxes in order of priority. Bymptom Areas: Please note up to four areas of concern below then put the lesignation letter in the lesignation letter in the lesignation letter in the lesignation																					
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How many times have you seen the vet with this condition?		
Have they received any other form of treatment?		
PAST MEDICAL HISTORY		
Neutering: If yes, at what age?	Yes	No
Operations:		
		••••••
Illnesses:		
		•••••
Any previous back, neck, joint, muscular problems:		
Have they had any trauma's (accidents / incidents) e.g. broken bo	nes? Yes	No
If yes, please give details:	103	140
Any eating / digestive problems? If yes, please give details:	Yes	No
Any allergies? If yes, please give details:	Yes	No
Have they ever been diagnosed with any neurological problems?	Yes	No
If yes, please give details:		

Any problems with their immune system (that you are aware or problems?	of) e.g. ears, r Yes	nose No
problems?	res	INO
	•••••	•••••
BEHAVIOUR PROBLEMS		
Nervousness: If yes, please give details:	Yes	No
		•••••
	•••••	•••••
Aggression:	Yes	No
If yes, please give details:		
		•••••
Any behavioural changes since the condition started?		
	• • • • • • • • • • • • • • • • • • • •	•••••
		•••••
GENERAL		
What food do you give your Pet?		
Any medication or supplements?		
How much exercise (dogs)		
Please complete the following after completing the questi	onnaire.	
I confirm that I have read the Patient Information document ale the pet to be treated in the manner described. I give my full consent to the examination and treatment of the I confirm that I am responsible for the payment of fees (including missed appointments or late cancellations.	pet.	
Owner/ Guardian Print Name:		
Owner/ Guardian Signed		-
D .		

GDPR PATIENT EXPLICIT CONSENT DATA PROTECTION AGREEMENT

Explicit Consent

I explicitly consent to you creating and storing medical records concerning my treatment, which may include details concerning my medication, treatment and other issues affecting my health conditions, in accordance with the General Data Protection Regulation (GDPR). I understand that these records will be retained for eight years, (or until I reach 25 in the case of someone aged 16 - 18), when treatment is ceased in order to comply with the Institute of Osteopathy legal guidelines. I understand that these records will be processed in accordance with your 2018 Privacy Notice, a copy of which I have seen.

I have read and understood the above information	and give my explicit consent:
Signed	Date:
Patient name:	
If acting in the capacity of a legal guardian, please s	state your role and authority
For future appointments and administration, our p	referred communication route/s is:
[] Telephone [] Email [] Post [] Other (please state)	
Promotional Information For the purposes of promoting healthcare including also like to stay in touch with you, with information	
For providing promotional information you can star methods:	y in touch with me using the following
[] Telephone [] Email [] Post [] Other (please state)	
Signed:	Date: