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?

See the website "Terms & Conditions" for how we control your personal information or ask to see a copy in our clinic.

What do you think is your Pet's problem?

……
……
……

What started it off?

……
……

How does it affect them?

……
……

Symptom Areas: Please note up to four areas of concern below then put the line designation letter in the boxes in order of priority.

A. ……..……..…..
B. ……..……
C. ……..
D. ……..

Severity of main symptoms: please tick

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Best imaginable — Moderate — Worst imaginable

How long have these issues been a problem? …..……

How many times have you seen the vet with this condition?
……
…

Have they received any other form of treatment?
……
……

PAST MEDICAL HISTORY

Neutering: Yes No
If yes, at what age?

Operations:
……..
……

Illnesses:
……
……
……

Any previous back, neck, joint, muscular problems:
……
……

Have they had any trauma's (accidents / incidents) e.g. broken bones?
Yes No
If yes, please give details:
……
……

Any eating / digestive problems? Yes No
If yes, please give details:
……
……

Any allergies? Yes No
If yes, please give details:
……
……

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 of) e.g. ears, nose problems? Yes No

……

BEHAVIOUR PROBLEMS

Nervousness: Yes No

If yes, please give details:

……

……

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 questionnaire.

I confirm that I have read the Patient Information document alongside and consent for the pet to be treated in the manner described.
I give my full consent to the examination and treatment of the pet.
I confirm that I am responsible for the payment of fees (including fees incurred due to missed appointments or late cancellations.

Owner/ Guardian Print Name: ……

Owner/ Guardian Signed…… ……..

Date…….

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 state your role and authority

……..

For future appointments and administration, our preferred communication route/s is:

[ ] Telephone
[ ] Email
[ ] Post
[ ] Other (please state) ……

Promotional Information
For the purposes of promoting healthcare including offers and advice the Practice would also like to stay in touch with you, with information that may be of interest to you.

For providing promotional information you can stay in touch with me using the following methods:

[ ] Telephone
[ ] Email
[ ] Post
[ ] Other (please state) ……

Signed: …….. Date: ……