Candlewell Clinic

Personal Details	
Patient Name:	
Address:	
	Post code:
E-mail:	
Contact Numbers:	
Home:	**Mobile:**
Work:	**Other:**
D.O.B:	

New Patient Questionnaire; Adult

GP Name:
Surgery Address:
Contact Number:

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

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? ….……

Medical History:

Please list any medications you are taking, either prescribed or over the counter including any homoeopathic or herbal remedies you are using:-

……
……
……

In the last 12 months, have you seen your GP / Hospital doctor / nurse for anything other than minor / routine medical matters? Yes No

In the last 12 months, have you seen a physiotherapist / osteopath / chiropractor (Please circle which) or other health professional? If so how many times?

Yes No Number

In the last 12 months have you had any of the following treatments?

Intra-articular steroid or other injection into joint.	Yes	No
X-ray or MRI or CT scan	Yes	No
Anthroscopy (keyhole surgery)	Yes	No
Been admitted to hospital.	Yes	No
Bone scan	Yes	No
Other medical procedure related to you condition.	Yes	No

Please note below anything found in these tests

……
……
……
……

Any previous history of any serious medical conditions, e.g. Cancer, Heart disease, Auto-immune disease, Diabetes, multisclerosis etc.? Please note below.

……
……
……
……

Do you have a history of circulatory, heart, blood pressure, or cholesteral level problems? Yes No

Do you have any breathing problems? Yes No

In the last 12 months, have you had any digestive problems? Yes No

In the last 12 months, have you had any type of kidney or bladder problems? Yes No

Any problems or changes with your bowel ? Yes No

Any gynaecological problems or changes? N/A for men Yes No

Any prostrate conditions? N/A for women Yes No

In the last 12 months, have you had any type of arthritis?	Yes No
In the last 12 months, have you had any problems with migranes or headaches?	Yes No
Any changes with your eyesight, e.g. loss or double vision?	Yes No
Any changes with your sense of smell, taste, or hearing?	Yes No
Have you ever been diagnosed with any neurological problems?	Yes No
Have you ever had any problems with depression / anxiety?	Yes No
Have you ever been diagnosed with any psychological disorder?	Yes No
Do you have any allegies?	Yes No
Do you have any other medical/surgical history? Please note.	Yes No
Have you had any trauma's (accidents / incidents)? Please list.	
Have you ever broken any bones?	Yes No
Have you ever been diagnosed with osteoporosis?	Yes No

How long have you been off work with this current episode?

☐ Less than 1 week ☐ 1 week ☐ 2-5 weeks ☐ 6-12 weeks ☐ 13 weeks or more

☐ 1 year or more ☐ Not away from work

All information you give to the Candlewell Clinic is confidential and held subject to the requirements of the Data Protection Act 1998, and kept within your osteopathic notes.

Please complete the following after completing the questionnaire.

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

Print Name: ……..

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:
……