**CONSULTATION FORM**

| Surname: | Title: |
| --- | --- |
| First Name: | D.O.B: |
| Address (incl. Postcode): | |
| Contact Phone No: | |
| E-Mail: | |
| Contact in case of emergency: | |
| GP Surgery / GP Name (if known) : | |

How did you hear about us? Recommendation/Web/Other

| **MEDICAL HISTORY** | Use this column for your answers/comments. |
| --- | --- |
| **Medication** (including birth control): Please outline any medication that you are taking |  |
| **Diagnosed Illnesses/conditions:** Including thyroid problems, epilepsy, diabetes, rheumatoid arthritis, cancer and any childhood illnesses. |  |
| **Surgery:** Any form of intervention including exploratory and dental work |  |
| **Trauma**: Car accidents, falls, broken bones, sporting injuries etc. |  |
| **Cardiovascular**: Any blood conditions, high/low pressure, thrombosis/phlebitis, heart problems, chest pain, palpitations, swollen ankles, shortness of breath, stroke, any family medical history |  |
| **Respiratory:** Any lung complaint - shortness of breath, cough, wheeze etc. |  |
| **Gastrointestinal:** Any digestive complaints – indigestion, nausea, constipation, diarrhoea or change to bowel habits, abdominal pain, bloating etc |  |
| **Urogenital/Gynaecological:** Any bladder complaints or change to habit, pain on urination, ovarian cysts, menstrual complaints or changes to cycle, pelvic pain etc.  Are you going through the menopause. |  |
| **Neurological**: Any nerve pain either local to an area or travelling into the arms or legs - pins and needles, numbness, weakness etc |  |
| **Childbirth**: Are you pregnant? If so, how many weeks.  Have you had children? If so, any problems during pregnancy or assisted conception. Labour complications- tearing, ventouse, forceps etc. Caesarean –elective or emergency. |  |
| **Allergies:** Please give details of any allergies you have |  |
| **Skin conditions:** any skin conditions not already noted |  |
| **Special tests:** Blood tests, x-rays, MRIs, CT scans, Ultrasound scans, DEXA scan - bone density etc |  |
| **Exercise and Hobbies**: done regularly or which may be contributing to any presenting complaint |  |
| **Other relevant information :** Is there anything else about your health and wellbeing you would like to tell us? |  |

Describe in your own words what brings you to see me, how you are feeling and how it’s affecting your daily life. Include when/how did it start; what makes it worse/better.

What’s your general feeling of Stress recently? What is your favourite activity to help you wind down and relax?

Have you ever suffered from anxiety and/or depression?

How do you rate your quality of sleep? Good/Fair/Poor

How many hours do you usually get?

**Declaration and Informed Consent**

The information I have given in this form is honest, accurate and correct to the best of my knowledge. The effects, benefits and risks associated with treatment have been explained to me. I have been given the opportunity to ask all the questions about the process, and all of my questions have been answered to my satisfaction. I consent for treatment to take place and understand that I can withdraw my consent at any time.

Client Signature

Date

**Data Protection Policy**

The Clinic fully complies with the most up to date Data Protection Policy and has a transparent approach to Data Processing which empowers individuals to know about the collection and use of their personal data. We collect data for ensuring we have the right information for assessing your suitability to treatment, for completing the appropriate treatment, for contacting you regarding appointment follow-ups and for a referral to GP or other healthcare practitioners if deemed necessary. Your data will only be viewed by clinic staff to ensure continuity of care is given and for standard clinic running purposes. We collect only data that is relevant to those purposes, and we keep it for 7 years. All information held will be treated as strictly confidential and will only be released to any other external party with the consent of the client.

I have read The Clinic’s Data Protection Policy (<https://www.unstoppablerhythms.com/privacy-notice/>) and consent to The Clinic processing records as outlined above and understand that I can withdraw my consent on the processing of data at any time.

Client Signature

Date