



# Luck's Yard Clinic

CHIROPRACTIC AND HEALTH CARE  
FOR THE WHOLE FAMILY

Date.....

Mr / Mrs / Ms / Miss

Married / single / divorced / widowed / civil partnership

Surname.....

Age.....

Forenames.....

Date of birth.....

Address.....

Home Tel.....

Work Tel.....

Postcode.....

Mobile.....

Email address.....

Occupation.....

Number of children.....

Previous occupation.....

Ages and sex.....

GP Name / Surgery:.....

May we write to your GP if we deem it important for your care? YES ☐ / NO ☐

How did you find out about us?.....

## Consent to examination and recording of my medical notes and personal details

*I consent to an examination and the collecting and appropriate use of my personal details and medical notes in accordance with GDPR requirements of 2018 as set out in the privacy document on page 4 (parent or legal guardian if under 16)*

Signed.....

Date.....

## Detailed Consent

*I hereby give consent for the following, having been given a clear understanding of why such treatments may need to be undertaken with the risks and the benefits of each. Please tick all that apply, and know that you have the right to amend these consents at any point during your treatment plan (parent or legal guardian if under 16).*

Treatment	Consent	Signed	Date
Acupuncture	<input type="checkbox"/>	.....	.....
Chiropractic	<input type="checkbox"/>	.....	.....
Massage	<input type="checkbox"/>	.....	.....
Deep Tissue Work	<input type="checkbox"/>	.....	.....

Where are your problems? *(please also mark the diagram)*

Neck ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐

Mid-Back ☐ Low-Back ☐ Buttock ☐ Hip ☐ Upper-leg ☐ Knee ☐

Calf ☐ Ankle ☐ Foot ☐ Toe ☐ *(please describe below)*.....

Do you have any of the following symptoms?

Numbness ☐ Tingling ☐ Burning ☐ Pins & Needles ☐ Cold/Hot ☐ Headaches ☐

Dizziness ☐ Weakness ☐ *(please describe below)*.....

How would you describe the pain?

Sharp ☐ Shooting ☐ Dull ache ☐ Burning ☐ Mixed ☐

Other ☐ *(please specify)*.....

How severe is the pain? *(0-10 scale, 0 = no pain, 10 = severe pain)*...../10

When did it first start?.....

What do you think caused it?.....

Is it getting worse / staying the same / getting better? *(please circle)*

Does anything make it better?.....

What seems to make it worse?.....

Is it worse in the morning or at the end of the day?.....

Does it wake you at night? Y/N

Have you had this before? Y/N If yes, how often?.....

Is this the worst episode? Y/N

What treatment have you had for this problem so far? *(Pain killers, GP, Physio, Osteo, Chiro)*

Have you had any headaches, neck or back problems before? *(please specify)*.....

Please list *any* accidents or falls you have had.....

..... *(include car accidents, sports injuries, falls etc)*

Have any members of your family (mother, father, grandparents, brother or sisters) suffered from any of the following conditions?

Diabetes ☐ Heart attack ☐ Stroke/TIA ☐ Arthritis ☐ Cancer ☐ Auto-immune ☐

Thyroid ☐ Epilepsy ☐ Nervous system ☐ Gastro-intestinal ☐

*(please specify)*.....

Do you suffer from any of the following problems?

Eye problems ☐

Double vision ☐

Dental problems ☐

Jaw pain ☐

Speech problems ☐

Swallowing difficulties ☐

Ringing ears ☐

Deafness ☐

Skin problems ☐

Chest pain ☐

Productive cough ☐

Difficulty breathing ☐

Wheezing ☐

Fainting ☐

Nausea/vomiting ☐

Loss of appetite ☐

Abdominal pain ☐

Incontinence ☐

Difficulty urinating ☐

Blood in urine ☐

Bladder or bowel problems ☐

Rectal bleeding ☐

Constipation ☐

Pain in reproductive organs ☐

Headaches ☐

Dizziness ☐

Tremors ☐

Inco-ordination ☐

Night sweats ☐

Mood swings ☐

Sleep disturbances ☐

Nervousness/anxiety ☐

Depression ☐

Muscle cramps ☐

Muscle pain ☐

Joint pain ☐

Please list all serious illnesses (*previous and current*).....

.....

Have you ever been hospitalised and for what?.....

Have you ever had an x-ray? Y/N If yes, When?.....

Have you ever broken any bones? Y/N If yes, when?.....

Have you had any of the following tests: Urine / Blood / CT Scan / MRI / Bone Scan (*please circle*) Why?.....

Date of last GP visit.....Reason for visit?.....

Last menstrual period.....

Last cervical smear.....

Last breast exam.....

Last prostate exam.....

Height.....Weight.....Have you lost / gained weight recently? (*please circle*)

Do you smoke or have you ever smoked? Y/N If yes, how many per day?.....

Do you drink alcohol? Y/N If yes, how many units per week?.....

Do you use any recreational drugs?.....

.....

Please list any current medications, vitamin or mineral supplements you take.....

.....

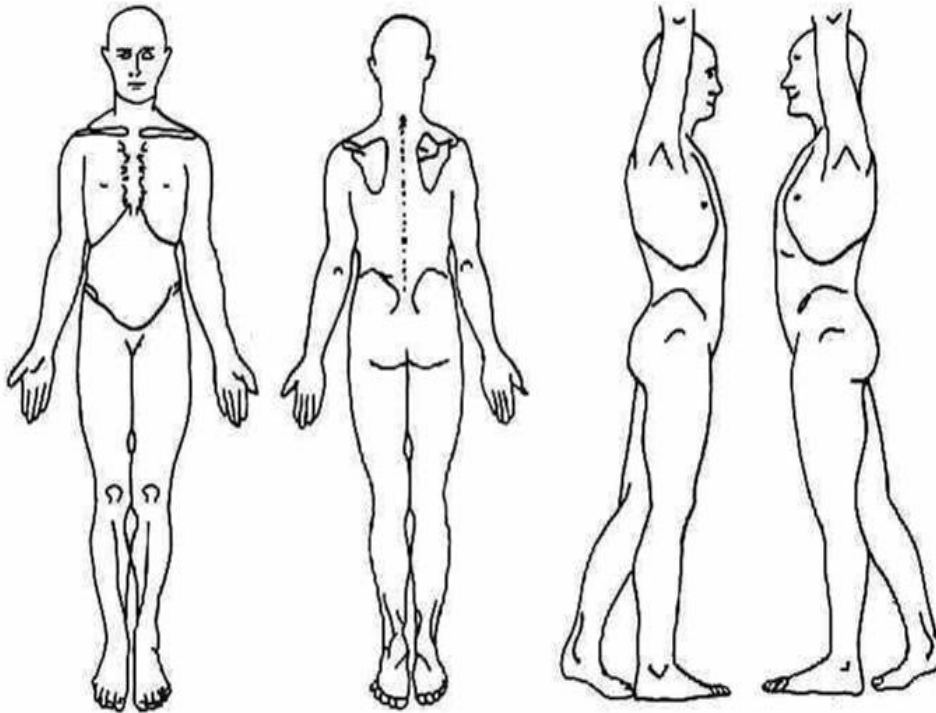
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Do you consider yourself in optimal / average / poor health? (*please circle*)

What are your hobbies/interests/sports?.....

# Patient Symptom Diagram

Please mark on the diagram all areas of your body where you feel the described sensations using the appropriate symbol. Include all affected areas.



**Numbness**                      = = =

**Burning**                        xxx

**Pins and needles**            ooo

**Stabbing**                        /////

**Aching**                         zzz

**Other**                            @@@

(please specify) .....

## DATA COLLECTION / USE POLICY

Healthcare

### Description of processing

The following is a broad description of the way this organisation/data controller processes personal information. To understand how your own personal information is processed you may need to refer to any personal communications you have received, check any privacy notices the organisation has provided or contact the organisation to ask about your personal circumstances.

### Reasons/purposes for processing information

We process personal information to enable us to provide health services to our patients, to maintain our accounts and records, promote our services and to support and manage our employees.

### Type/classes of information processed

We process information relevant to the above reasons/purposes. This information may include:

- personal details
- family details
- lifestyle and social circumstances
- goods and services
- financial details
- employment and education details

We also process sensitive classes of information that may include:

- physical or mental health details
- sexual life
- racial or ethnic origin
- trade union membership
- religious or other beliefs of a similar nature
- offences and alleged offences

Signed:

Date:

.....

.....

Who the information is processed about

We process personal information about our:

- patients
- customers and clients
- staff
- suppliers
- business contacts
- professional advisers

Who the information may be shared with

We sometimes need to share the personal information we process with the individual themselves and also with other organisations. Where this is necessary we are required to comply with all aspects of the Data Protection Act (DPA). What follows is a description of the types of organisations we may need to share some of the personal information we process with for one or more reasons.

Where necessary or required we share information with:

- healthcare professionals
- social and welfare organisations
- central government
- business associates
- family, associates and representatives of the person whose personal data we are processing
- suppliers and service providers;
- financial organisations
- current, past and prospective employers;
- employment agencies and examining bodies

### Additional reasons

#### Undertaking research

Personal information is also processed in order to undertake research. For this reason the information processed may include name, contact details, family details, lifestyle and social circumstances, financial details, goods and services. The sensitive types of information may include physical or mental health details, racial or ethnic origin and religious or other beliefs. This information is about survey respondents. Where necessary or required this information may be shared with customers and clients, agents, service providers, survey and research organisations.

**FULL DOCUMENT / DETAILS AVAILABLE ON REQUEST**