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PATIENT REGISTRATION FORM – PLEASE COMPLETE ALL SECTIONS IN CAPITALS
This questionnaire is for your safety, as well as our information. Thank you for your co-operation

Title Mr/Mrs/Miss/other: _____ First Name: _____

Surname:_____ Date of Birth: _____

Address:_____

Post Code: _____ Contact Telephone: _____

Email: _____

Occupation: _____

GP Name and Full Postal Address: _____

_____

How did you find out about us? (Please circle):

Google Recommendation Facebook Instagram Other (please state): _____

Have you had or experienced any of the following, *if yes please tick and explain below:*

Headaches	Cancer	Osteoporosis	Other Fractures
Heart Conditions	Car Accident	Arthritis	Gynaecological Conditions
Epilepsy	Diabetes	Bladder Problems	HRT
Pacemaker	Surgery	Spinal Fractures	Skin Conditions
Thyroid Problems	Liver Problems	Kidney Problems	Bowel Problems

_____

Are you currently seeing your doctor for any other condition or taking any prescription medicine?

_____

Terms and Conditions

I consent to the practitioner carrying out a full assessment and treatment as required, including joint and spinal mobilisations, acupuncture, sports massage, cupping therapy, zinc oxide and kinesiology taping.

We accept no liability whatsoever for any injury or death unless the same is caused directly by negligence of one of our Sports Therapists in the course of a treatment session.

I understand my G.P. may be informed of my attendance and progress, unless I request otherwise. Do not inform my GP [ ] (tick box)

In line with new General Data Protection Regulation 2018 I consent to my submitted data being collected and stored as part of my medical notes [ ] (tick box)

I confirm the above information is accurate and accept the above terms and conditions agreeing to abide by them:

SIGNED: _____ **DATE:** _____

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Covid- 19 Screening for a face to face appointment

Have you ever had a COVID- 19 test, this includes PCR, Antigen and Antibody tests? Y [ ] N [ ]

If you answered yes, please state the date of test/results: _____

Was the test Positive? Y [ ] N [ ] Unclear [ ]

If you tested positive, did you follow a period of quarantine? Y [ ] N [ ]

Please comment: _____

Have you been adhering to social distancing measures: Y [ ] N [ ]

How do you feel today:

I feel physically normal [ ]

I feel unwell [ ]

To the best of my knowledge, I have not been in contact with anyone with **confirmed** Covid- 19

I have NOT [ ] I have [ ]

(If you have answered Yes to any of the above you will be unable to attend your face to face appointment today, until you have either completed a Coronavirus test that is negative, or followed a period of quarantine)

High Risk and Shielding Individuals

Do you fall into a high risk or shielding group Y [ ] N [ ]

Extremely High Risk Individuals

Do you fall into an extremely high risk group Y [ ] N [ ]

**If you are unsure please ask the Clinician to show you the document that has more details of these groups. This is also available on our website to read.

**** If you have answered YES to being in the High Risk Group please discuss with your Clinician if a face to face appointment is necessary. It is at your own risk to continue with a face to face appointment in the current Covid 19 pandemic.

**** If you have answered YES to the Extremely High Risk Group it is NOT advised that you attend a face to face appointment until further notice with the current Covid- 19 Pandemic.

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Expectations of a face to face appointment

I understand that coronavirus may not cause symptoms in some people and is currently causing a pandemic which means healthcare services are required to operate differently Y [ ] N [ ]

I confirm that I am not in the clinically extremely vulnerable category and therefore advised to shield at home by the government Y [ ] N [ ]

I understand that I have been made aware of a change of clinical practice during the pandemic, and that my Clinician will be wearing a mask and visor, apron and gloves during my treatment as set by Public Health authorities Y [ ] N [ ]

I understand that I may receive less/ minimal/ no hands on therapy if not necessary or appropriate during my appointment Y [ ] N [ ]

I confirm I have been made aware of the change in practice before my scheduled appointment, to allow me time to cancel my appointment or seek any additional information I require Y [ ] N [ ]

I confirm I am aware of the Clinic's hand sanitisation on entry and exit and that I may be asked to wear a face mask. I will also maintain social distancing of 1 metre + where able Y [ ] N [ ]

I confirm I am aware of the Clinic's requirement for contactless payment Y [ ] N [ ]

I understand the toilet facilities and waiting area will be closed to ensure no cross over or contamination between patients Y [ ] N [ ]

I understand I must wait in my car or outside of the building until my scheduled appointment time to ensure minimal contact or cross over with any other people or patients in the building Y [ ] N [ ]

I have had the opportunity prior to my appointment to ask my Clinician any questions I feel necessary

Y [ ] N [ ]

I agree to a face to face appointment for myself or my child Y [ ] N [ ]

Signed:_____ Date: _____