Privacy Policy

Chiropractic First.

Name (print) _____ Date of Birth _____

Your personal data is important to us. We collect data relevant to medical practise and UK law. Please read our Privacy Policy at the back of your welcome pack, which is also available in reception and on the website.

Our Privacy Policy will tell you why we collect your data, how we store it, who has access to it and about your rights to accessing this data.

In addition we reserve the right to contact you via email, text message or phone in relation to appointment reminders, requests and other aspects of your care.

If at any time you wish to stop receiving communications, please send an email with the subject line: **Unsubscribe** to drlewis@chiropracticfirst.co.uk

I have read and understood the Chiropractic First - Privacy Notice GDPR and I accept the above terms and conditions.

Signed* _____ Date _____

**Please note, if the patient is under 16 years of age, a parent or legal guardian is required to consent on their behalf by signing this form, please also print your name and state your relationship to the patient.*

01273 324466
info@chiropracticfirst.co.uk
chiropracticfirst.co.uk

82 Goldstone Villas
Hove, East Sussex
BN3 3RU

Cancellation Policy

Name (print) _____ Date of Birth _____

To assist you in your care, we will automatically enroll you in our text reminder service. Please let us know if you would like to opt out of this service.

Please ensure you also make a note of your appointment at the time of booking as managing your appointment remains your sole responsibility. We also ask that you arrive 5 minutes before your appointment time.

Please note, we require 24 hours notice to change or cancel any appointment and we reserve the right to charge for changes or cancellations without adequate notice.

Missed appointments will be charged in full.

I have read and understood the Cancellation Policy at Chiropractic First and I accept the above terms and conditions.

Signed* _____ Date _____

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New Patient Form

Personal details

Name _____ Date of Birth _____

Address _____ Post Code _____

Mobile phone _____ Other phone _____

Email _____

Occupation _____ If you have children, please list their ages _____

GP Surgery name & address _____

-I consent to the chiropractor sharing my medical information with my GP ☐ Yes ☐ No

Who may we thank for referring you to our clinic? _____

Are you currently pursuing an insurance claim for personal injury? _____

Health profile

(please tick appropriate box)

	Yes	No	I used to
Do you smoke/vape?	☐	☐	☐
-if yes, how many per day? _____			
Do you drink alcohol?	☐	☐	☐
-if yes, how many glasses per week? _____			
Do you drink coffee, tea or other caffeinated drink?	☐	☐	☐
-if yes, how many cups per day? _____			
Do you take any medications/recreational drugs?	☐	☐	☐
-if yes, please specify name and dose _____			
Do you play any sports?	☐	☐	☐
-if yes, please specify _____			
Have you ever had any serious fall/physical trauma (e.g. car accident)?	☐	☐	
-if yes, please specify _____			
Have you ever had any surgery?	☐	☐	
-if yes, please specify _____			
Have you ever been under chiropractic care?	☐	☐	
-if yes, how long ago? _____			

Self-evaluation

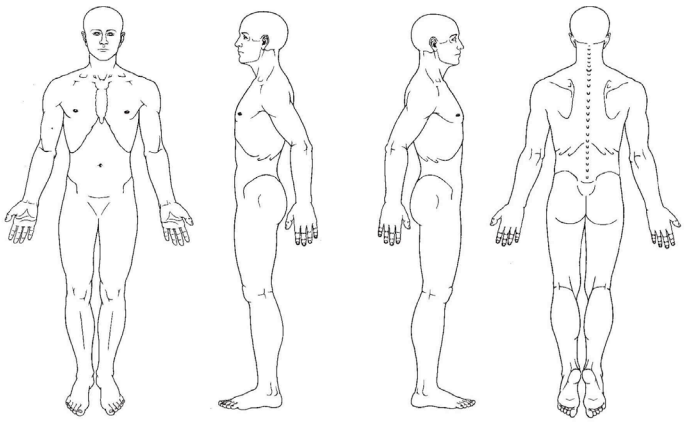
(please circle appropriate number)

Stress levels at work	(none)	0	1	2	3	4	5	6	7	8	9	10 (extreme)
Stress levels at home	(none)	0	1	2	3	4	5	6	7	8	9	10 (extreme)
Quality of diet	(poor)	0	1	2	3	4	5	6	7	8	9	10 (excellent)
Level of exercise	(poor)	0	1	2	3	4	5	6	7	8	9	10 (excellent)
Quality of sleep	(poor)	0	1	2	3	4	5	6	7	8	9	10 (excellent)
General health	(poor)	0	1	2	3	4	5	6	7	8	9	10 (excellent)

About your current symptoms

(please circle on the outline below the areas where you are experiencing symptoms)

R front L L side R side L back R



Please describe your pain
(tick appropriate box)

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Constant
- ☐ Intermittent (comes & goes)

What caused your symptoms to start? _____

How long have you been experiencing these symptoms? _____

Over time, are your symptoms ☐ Getting worse ☐ Getting better ☐ Staying the same

Activities affected by your symptoms ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Please circle your level of pain (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Have you seen other health professionals about this problem? ☐ Yes ☐ No

-if yes, please list _____

Medical History

(If you have ever experienced any of the following symptoms/diagnosis, please tick accordingly)

Musculoskeletal system
__Scoliosis
__Jaw Pain
__Neck pain
__Whiplash
__Back pain
__Hip pain
__Leg pain
__Knee/foot pain
__Arm pain
__Wrist/hand pain
__Fracture
__Osteoporosis
__Arthritis
__Morning stiffness
__Tendinitis
__Muscle weakness
__Disc problem
__Hernia

Nervous system
__Memory Loss
__Migraine
__Headache
__Epilepsy
__Fibromyalgia
__Sciatica
__Pins & Needles

Respiratory/CV systems
__Chest pain
__Shortness of breath
__Fainting
__Asthma
__Heart problem
__Lung problem
__Poor circulation
__Leg cramps
__High blood pressure
__Stroke

Eye-Ears-Throat
__Vision disturbance
__Sinus Problem
__Vertigo/Dizziness
__Ringing in ears
__Ear infection
__Difficulty swallowing
__Throat infection

Digestive System
__Diabetes
__Heart burn/acid reflux
__Stomach pain/ ulcer
__Constipation
__Diarrhea
__Liver problem
__Gallbladder problem
__Irritable bowel
__Haemorrhoids
__Eating disorder

Urinary Tract
__Kidney problem
__Bladder problem
__Incontinence
__Urinary tract infection

Women
__Endometriosis
__Fibroid
__Menstrual cramps

Men
__Prostate problem
__Impotence

Other
__Sleeping problem
__Depression/anxiety
__HIV/AIDS
__Thyroid problem
__Cancer
__Allergies

The statements made on this form are accurate to the best of my knowledge. I consent to this information and any subsequent information regarding my examination and treatment to be retained and stored by Chiropractic First - Hove in accordance with the clinic Privacy Policy and the General Data Protection Regulation (GDPR) (EU) 2016/679.

Signed* _____ Date _____

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