

Patient registration form

Personal details

PLEASE WRITE LEGIBLY

Date:	Age:
First Name(s):	Surname:
Address:	Postcode:
Phone (home):	Phone (work):
Phone (mobile):	Email:
Date of Birth:	Male / Female:
Height:	Weight:
Occupation:	Attach business card (if available):
Blood Type:	

Medical details

<u>GP Details</u>		<u>Consultant/ Specialist Details</u>	
Name:		Name:	
Address:		Address:	
Postcode:		Postcode:	
Phone:		Phone:	
<u>Private Medical Insurance Details</u>		Policy No:	
Name of Insurer:		Pre Authorisation No.:	
<u>Source of Referral:</u>			
<input type="checkbox"/> GP referral	<input type="checkbox"/> Consultant referral		
<input type="checkbox"/> Friend/ family – name:	<input type="checkbox"/> Back Clinic website		
<input type="checkbox"/> Google.com	<input type="checkbox"/> Yell.com		
<input type="checkbox"/> You are a previous patient	<input type="checkbox"/> Magazine		
<input type="checkbox"/> Other – please specify:			

Medical details *(It is important that you complete this form accurately)*

Please circle correct answer

1. Is your condition the result of a work accident? Yes No

2. Is your condition the result of a car accident? Yes No

If 'yes' to either of the above, are you involved in litigation? Yes No

3. Are you able to work with your condition? Yes No

If 'no' how long have you been off work? _____

4. When and how did your condition start?

5. Have you ever been diagnosed with or had a history of the following?

Please tick

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart condition / Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Cancer of any kind | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Spine fracture | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Spine infection | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Lung condition | <input type="checkbox"/> Osteo Arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gout |
| If yes, do you take insulin? | <input type="checkbox"/> Disc Hernia / Prolapse | <input type="checkbox"/> Other (Please Specify) |
| Yes No | | |
| <input type="checkbox"/> Hypermobility | | |

If any of the above have been ticked, please give further details:

6. Do you smoke? Yes No

If yes how many per day? _____

7. Have you had recent or major surgery of any kind? Yes No

If 'yes' please give further details:

8. Are you pregnant, or might you be pregnant? Yes No

9. Are you taking any medication? Yes No

Please specify _____

10. Do you do any exercise? Yes No

If yes what type and frequency?

11. Do you compete at professional level? Please specify

12. Have you undergone any of the following treatments for your current problem?

Please tick

Did it help

<input type="checkbox"/> Physiotherapy	No. of sessions _____	Yes	No
<input type="checkbox"/> Osteopathy	No. of sessions _____	Yes	No
<input type="checkbox"/> Chiropractic	No. of sessions _____	Yes	No
<input type="checkbox"/> Injection	No. of sessions _____	Yes	No
<input type="checkbox"/> Other – please specify _____	No. of sessions _____	Yes	No

Is there any other information you believe we should know?

Health & wellbeing goals

To help you reach your optimal health and wellness goals, we need to identify the areas you want to improve. Please indicate below how you feel about the following areas of your health on a scale of 1 to 5.

	Very dissatisfied				Very satisfied
Amount of energy	1	2	3	4	5
Amount of body fat	1	2	3	4	5
Strength	1	2	3	4	5
Ability to cope with stress	1	2	3	4	5
Ability to relax	1	2	3	4	5
Wake up refreshed	1	2	3	4	5
Posture	1	2	3	4	5
Sleep patterns	1	2	3	4	5
Amount of lower back problems	1	2	3	4	5
Physical appearance	1	2	3	4	5
Overall physical fitness	1	2	3	4	5
Overall mood and self confidence	1	2	3	4	5

Short term goals:

Long term goals:

Terms and Conditions (Please read thoroughly)

- Your treatment will be administered by Chartered and State Registered practioners.
- We may send information about RejuvBody to your GP/ Consultant. Any Findings and Reports may be passed back to your GP/ Consultant.
- We are registered providers of most private medical insurers, **however we are unable to offer direct settlement arrangements and therefore require payment in full on the day of your treatment.**
- If you wish to claim your treatment costs you will need to contact your insurer and comply with the conditions of your individual policy.
- We will be pleased to complete and sign your forms and provide statements of your payments
- Please give us **24 hours notice** if you need to change your appointment times or dates.
- **We will charge a full fee for non-attendance if you do not attend and fail to notify us within 24 hours. These payments will be taken directly from your credit card or an invoice sent. Immediate payment is required on receipt of any invoice.**

By signing you agree to the above conditions and give your consent to treatment

Print name: _____

Signature: _____

Date: _____

Roland Morris Disability Questionnaire

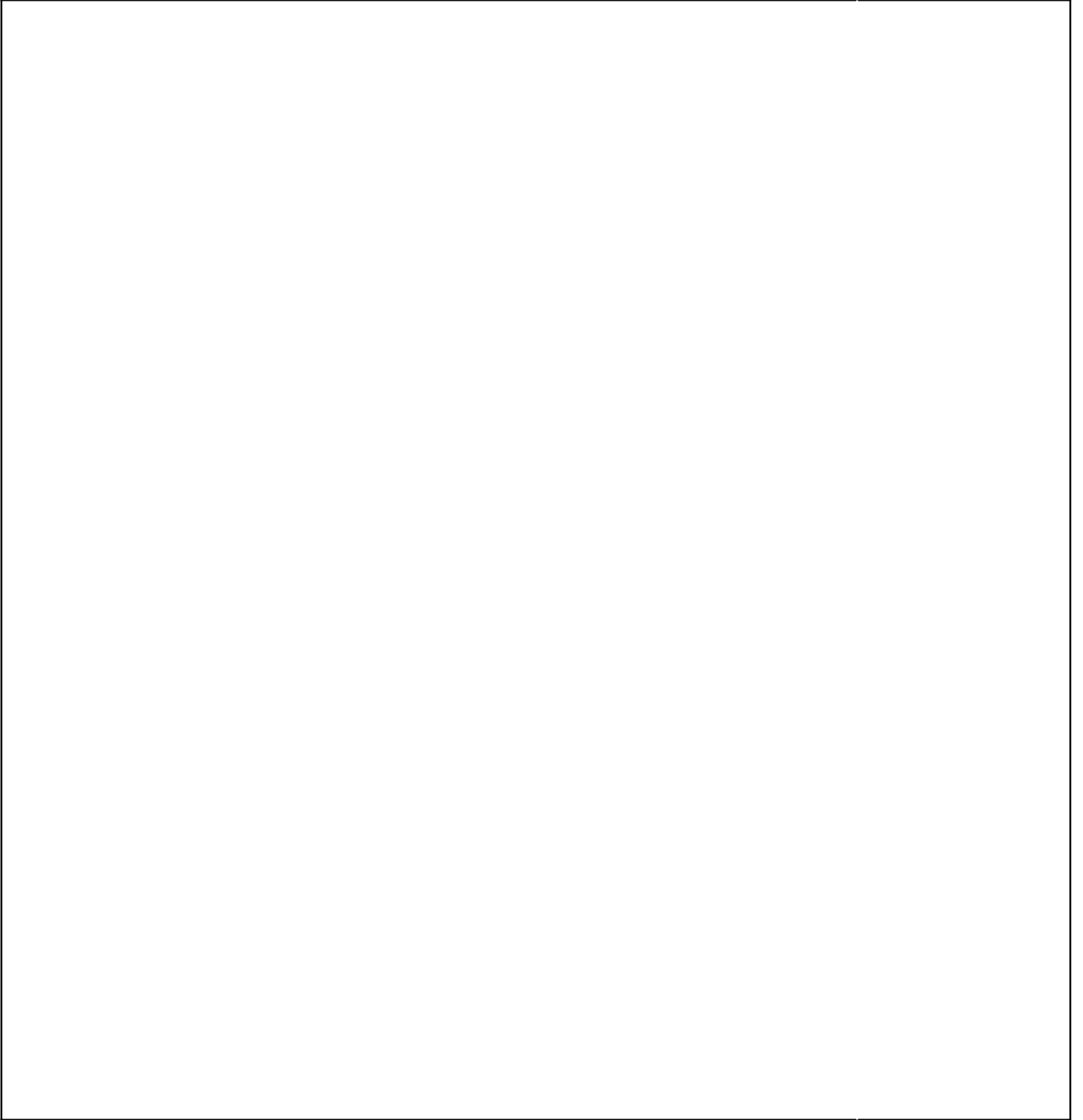
Patient Name:

Date:

PLEASE READ BEFORE COMPLETING:

When your back hurts you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you TODAY. As you read this list, think of yourself TODAY. When you read a sentence that describes you TODAY, circle 'YES'. If the sentence does not describe you, circle 'NO'.

rejuvbody



rejuvbody

1. I stay home most of the time because of my back	YES	NO
2. I change position frequently to try and get my back comfortable	YES	NO
3. I walk more slowly than usual because of my back	YES	NO
4. Because of my back, I am not doing any of the jobs I usually do around the house	YES	NO
5. Because of my back, I use a handrail to get upstairs	YES	NO
6. Because of my back, I lie down to rest more often	YES	NO
7. Because of my back, I have to hold on to something to get out of an easy chair	YES	NO
8. Because of my back, I try to get other people to do things for me	YES	NO
9. I get dressed more slowly than usual because of my back	YES	NO
10. I only stand up for short periods of time because of my back	YES	NO
11. Because of my back, I try not to bend down or kneel	YES	NO
12. I find it difficult to get out of a chair because of my back	YES	NO
13. My back is painful almost all the time	YES	NO
14. I find it difficult to turn over in bed because of my back	YES	NO
15. My appetite is not very good because of my back	YES	NO
16. I have trouble putting my socks (or tights) on because of the pain in my back	YES	NO
17. I only walk short distances because of my back pain	YES	NO
18. I sleep less well because of my back pain	YES	NO
19. Because of my back pain, I get dressed with help from someone else	YES	NO
20. I sit down for most of the day because of my back	YES	NO
21. I avoid heavy jobs around the house because of my back	YES	NO
22. Because of my back pain, I am more irritable and bad-tempered than usual	YES	NO
23. Because of my back, I go upstairs more slowly than usual	YES	NO
24. I stay in bed most of the time because of my back	YES	NO

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