The Chandos Clinic Ltd. – Osteopaths
21 Chandos Road, Redland. Bristol. BS6 6PG
Registration Form for Neal's Yard Therapy Rooms
11 Northumberland Place Bath BA1 5AR
Adult/Child Registration Form

Medical alert

Title_____ **Given name**_____ **Date of Birth**_____

Surname_____ **Todays Date** _____

Address_____

_____**Post Code**_____

Email_____

Mobile number_____

Land line number_____

Work number(s) and extension_____

Occupation _____

G.P. Name & Address _____

_____

How do you hear about Giles Cleghorn working at Neal's Yard in Bath?

Family member ☐

Friend ☐

Work colleague ☐

Professional ☐

Internet ☐

Other advertising – ☐ **please state from where**

How did you find the phone number for Neal's Yard Therapy Rooms?

Given by the person who referred you ☐

The internet ☐

Yellow pages ☐

Passing the office ☐

Other ☐

DO you have medical insurance? No Yes Name of Insurer _____

1) I understand that 24 hours notice is required if I wish to cancel an appointment otherwise I will be charged the full fee.
This also applies for late arrival and missed appointments ☐

2) I authorise you to disclose relevant medical information to the GP stated above ☐

3) I wish to receive a newsletter by email ☐

Please fill in circling your answers. Do not give details: your practitioner will do this with you. If in doubt leave blank.

In your past medical history have you ever had:-

Major Illness(s)	no	yes
Mental health problems	no	yes
Road traffic collisions	no	yes
Whiplash	no	yes
Falls & major accidents	no	yes
Sports injuries etc.	no	yes
Broken bones or fractures	no	yes
Dislocations of joints	no	yes
Operation(s)	no	yes

Do you take ANY Drugs &/or medication(s) no yes

General Health

Would you say you general health is GOOD or POOR?

Do you suffer from:-

Allergies	no	yes
Headaches and or migraines	no	yes
Sinus problems	no	yes
Ear or hearing problems	no	yes
Sleep difficulties	no	yes

Please fill in circling your answers. Do not give details: your practitioner will do this with you. If in doubt leave blank.

Medical problems. **Do you suffer from:-**

Diabetes, thyroid or

other endocrine problems no yes

Heart problems no yes

Blood Pressure no yes

Chest pain or discomfort no yes

Breathing difficulties no yes

Asthma no yes

In any part of your body do you have the sensation of:

Pins and needles no yes

Numbness no yes

Do you or have you suffered from fainting or fits no yes

Do you have any problems with your vision no yes

Do you donate blood no yes

Female

Have you or do you have any difficulties with:-

Menstrual Periods no yes

Gynaecological problems no yes

The delivery of your children no yes

Bladder problems no yes

Difficulty passing urine no yes

Male

Do you have any problems with erectile dysfunction no yes

Difficulty passing urine no yes

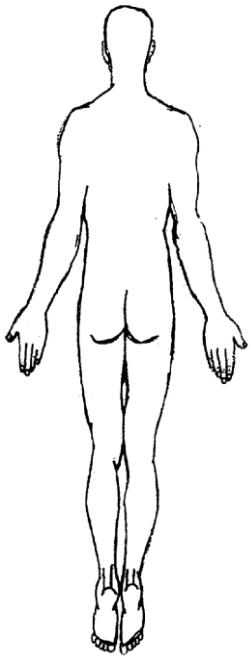
I have to the best of my knowledge given truthful and accurate answers to the above questions

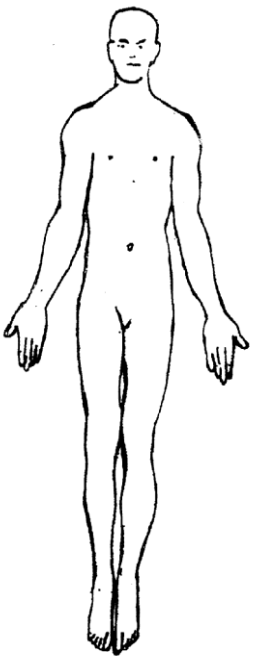
Please SIGN_____ **DATE**_____/_____/_____

OFFICE USE ONLY

Review and record changes in Medical History at new visits, record no changes as appropriate

Details of chief complaint(s) including history of onset and history of previous episodes





Medical information about chief complaint(s)

GP / Consultant /Hospital/ Other Clinical Visits

Treatment/ referrals/ prescriptions given

X-Ray/MRI/CT/Ultra Sound Scans

Other test results / and conclusion(s)

Medical examination(s)

Blood pressure / auscultation / respiratory sounds

Reflex examination(s) & special senses, muscle strength tests

ROM Tests

Relevant family history of diseases

Osteopathic Examination and Preliminary Treatment Plan/Advice/ Referrals and any Treatment Given

Review Medical History at new visits and record all or no changes