oakwell health

Confidential Records

Name _____

Home Phone _____ Mobile _____

Address _____

_____

_____

Email _____

Date of birth_____ Gender _____

Emergency contact_____

Where did you hear about us? _____

Private Health Care Cover? _____

Client Statement & Agreement

I confirm that I have read the patient consent leaflet and give permission to being treated in the manner described. I confirm that I am responsible for the payment of fees prior to the treatments and any insurance claims will be paid to myself after claiming.

I am happy for my GP to be contacted if necessary - **YES / NO**

Signed: _____ Date _____

Parent signature and present if under 18: _____

Are you happy to be contacted by email with information & promotions?

YES / NO

I acknowledge that all the information on this consultation sheet is accurate and correct to the best of my knowledge. I accept full and complete responsibility for my own emotional and/ or physical wellbeing both during and after the treatment. I agree to inform Oakwell Health of any changes to my circumstances during any subsequent treatments. I realise that any advice given to me to carry out between sessions is important and I agree to make every effort to carry this out. I understand that no claim to cure has been made and realise that the treatments should not replace conventional treatments and that my data will be stored for 7 years under GDPR compliance.

Signed: _____ Date _____

Parent signature and present if under 18: _____

<u>Medical History</u>

Do you have or have you ever experienced: (Please circle)

High/low blood Pressure, depressive illness, pacemaker, epilepsy, panic attacks, stroke, anxiety, diabetes, migraine, asthma, heart disease, pregnancy, operation, phlebitis, infectious illness, dysfunction of the nervous system, varicose veins, localised inflammation, bruising, open wounds, scar tissue, swelling, arthritis.

Please give details if you circled any of the above or any other conditions you think might be relevant:

_____

_____

_____

_____

Are you on any medication? _____

_____

Addictions: _____

Allergies: _____

Symptoms you have now and in the Past

Pain - Where does it hurt? _____

- How does it feel? _____

Any pins and needles? _____ Any numbness? _____

Breathing problems? _____ Chest Pain? _____

Palpitations? _____ Constipation? _____ IBS? _____

Diarrhoea? _____ Heartburn? _____

Please share your history of accidents/surgeries/broken bones:

_____

_____

_____

Is a GP Referral Required? **YES / NO**

Do you have permission from your GP for this treatment? **YES / NO**

GP Name (if known): _____

Practice Name: _____

Address: _____

Do you consent to the use of dry needles in your treatment, if recommended by your practitioner? YES / NO

Practitioner Notes:_____