

The Chartered Society of Physiotherapy requires that all patients receiving treatment by Chartered Physiotherapists are registered for Medical audit under the Professional Code of Practice. To ensure that our information is accurate we request that you complete the following, which will also serve as consent to treatment terms. All information will be treated with appropriate confidentiality.

NAME:		DATE OF BIRTH:	
ADDRESS:			POSTCODE:
TEL: Home:		Work:	
Mobile:		Email:	
GP NAME:		TEL:	
GP'S ADDRESS:			POSTCODE:

Please state how you heard of us:		
<input type="text"/>		
IF YOU ARE AN INSURANCE PATIENT, PLEASE COMPLETE DETAILS BELOW:-		
Insurance Company	Patient Number	Authorisation Number/Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Excess Details:	<input type="text"/>	

- **Treatment is undertaken by mutual understanding of the aims of treatment. All relevant information related to the injury is to be given during the initial assessment. If necessary, please provide x-rays, scans as soon as they are available.**

PATIENT'S RESPONSIBILITY:

1. Consent for treatment is the responsibility of the patient, but correspondence with the GP or referring Consultant may be necessary with prior agreement;
2. To inform GP of treatment;
3. **Check the terms of your insurance policy and advise of any excess details – please ensure excesses are paid for promptly;**
4. If you are paying directly for your treatment, please pay at the end of each visit.

Consent to treatment:

1. I agree to abide by the conditions of the CSP and to terms of treatment by members of the Organisation of Chartered Physiotherapists in Private Practice (OCPPP).
2. I accept that referral to Consultants and other practitioners will be on a private basis unless otherwise arranged.
3. I undertake to pay fees, which are charged by consultation and treatments at the standard rate, and to pay for appliances which may be prescribed.
4. I acknowledge that payment for treatment is my responsibility as are claims made to insurance companies. If there is an excess on my insurance policy, I agree to pay this direct to Back on Track Limited.
5. A cancellation charge may be levied if less than 24 hours notice is given.
6. If I miss an appointment, I agree to pay a DNA charge.

SIGNED..... DATE.....
 (Parent or Legal Guardian must sign if under 16)

We may wish to contact you from time to time with information about the services we offer or the latest research concerning medical conditions. Please tick the box if you do NOT wish to receive this information.

Office use only

1	2	3	4	5	6	7	8	9	10
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General Health / Medical History

Please tick any boxes that are relevant

Heart (e.g. murmur/pacemaker/disease)	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Lungs (e.g. asthma)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Previous surgery	<input type="checkbox"/>	Long term steroid use	<input type="checkbox"/>
Do you smoke	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>
Neck and Back conditions			
Pain worsens when lying on back	<input type="checkbox"/>	Problems with speech	<input type="checkbox"/>
Severe night-time pain	<input type="checkbox"/>	Problems with swallowing	<input type="checkbox"/>
Disturbed walking pattern	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Bladder or bowel disturbances	<input type="checkbox"/>	Double vision	<input type="checkbox"/>

If you have ticked any of the above, please give details: _____

List any medications you are currently taking : _____

Have you had any other treatments (e.g. Osteopath/Acupuncture) : _____

Do you take part in any regular sporting activities? : _____

