



Registration & Consent Form

PLEASE WRITE CLEARLY IN BLOCK CAPITALS

CLINIC _____

FIRST APPOINTMENT DATE _____

First Name _____		Surname _____ (Mr/Mrs/Miss/Ms/Other) _____	
Address _____ _____ _____			
Post Code _____			
Contact Numbers			
Home _____		Mobile _____	
Work _____		Email _____	
DOB _____	AGE _____	MALE / FEMALE	
Occupation	_____		
Sport (s)		Please indicate level played	
Sports Club (if applicable)		_____	
GP		GP Practice	
Referring Consultant (if applicable)		Hospital/Clinic	
Insurance Company		Policy or Authorisation Number	
How did you hear about PhysioActive?	Personal Recommendation <input type="checkbox"/> GP <input type="checkbox"/> Insurance Company <input type="checkbox"/> Sports Club <input type="checkbox"/> School <input type="checkbox"/> Yellow Pages (directory) <input type="checkbox"/> Yell.com <input type="checkbox"/> Leaflet <input type="checkbox"/> Passing <input type="checkbox"/> Previous Patient <input type="checkbox"/> <input type="checkbox"/> Internet (Please give details) <input type="checkbox"/> Other (please give details)		

Medical Checklist

Have you had / do you have any of the following conditions? If yes, please tick the relevant box.							
Headaches		Car Accident		Bladder/Bowel problems		Long term back pain	
Drop Attacks		Other Accident		Spinal Fractures			
Epilepsy		Osteoporosis		Other Fractures			
Diabetes		Cancer		Gynaecological conditions			
Heart Condition		Anti-coagulant therapy		HRT			
Pacemaker		Steroid treatment		Skin conditions			
Have you had any operations?				YES / NO			
If yes, please give details							
Are you currently seeing your doctor for any other medical condition?				YES / NO			
If yes, please give details.							

Consent to Treatment and Payment Terms

I confirm the information I have given is accurate and hereby give consent to receiving treatment at PhysioActive on this and any subsequent occasion.

I understand that physiotherapy treatment appropriate to the diagnosed condition will be given only by a chartered and HPC recognised physiotherapist.

I understand that sports massage treatment, podiatry treatment and acupuncture will be given only by a qualified and registered practitioner.

I consent to acupuncture treatment.

I understand it is PhysioActive's policy to write to my GP when I commence treatment with PhysioActive and give my consent.

I agree to take full responsibility for the payment of all treatment costs, including cancellation charges and non-attendance fees. I understand that failure to attend for an appointment without giving 24 hours' notice will incur a charge.

Patients with private health insurance: I agree to take full responsibility for the payment of any treatment costs not covered by my private health insurance, including shortfall payments and non-attendance fees.

Signed.....

Date.....

(If patient under 18, parent/guardian please sign)