

**Sport Rehabilitation & Massage Registration Form 2 Eleanor**

Title ..... First Name/s .....

Surname ..... Date of Birth.....

Address .....

.....

Post Code..... Tel. .... Mobile .....

Email .....Occupation .....

GP name ..... GP tel. ....

GP address .....

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Emergency contact – name and contact number

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How did you find out about us?	Family	Friend	GP	Web	Facebook	YP	Advert	Chiro Referral	Other

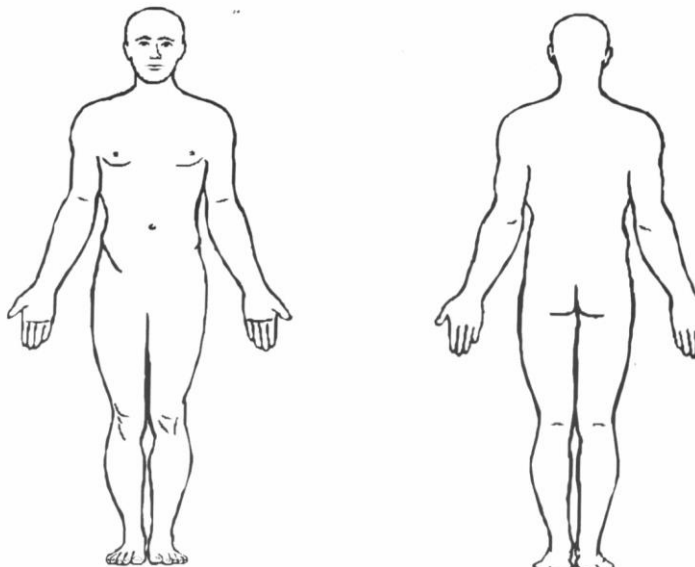
Marital Status: S M P D S W

Lifestyle Active/Sedentary..... Hobbies .....

Reason(s) for treatment: .....

.....

Indicate pain and/or stiffness by shading in the area



Any major surgeries (please supply details and dates): .....

.....

Please tick any conditions you are experiencing or have experienced:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Herniated disks                         | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Numbness or tingling     |
| <input type="checkbox"/> Road traffic accident                   | <input type="checkbox"/> Migraines                      | <input type="checkbox"/> Respiratory .....        |
| <input type="checkbox"/> Osteoporosis                            | <input type="checkbox"/> Strain/Sprain                  | <input type="checkbox"/> Cardiovascular .....     |
| <input type="checkbox"/> Arthritis- OA/RA/other<br>location..... | <input type="checkbox"/> Bursitis                       | <input type="checkbox"/> Infectious disease ..... |
| <input type="checkbox"/> ME/Fibromyalgia                         | <input type="checkbox"/> Back, neck or shoulder<br>pain | <input type="checkbox"/> Neurological.....        |
| <input type="checkbox"/> Chronic fatigue                         | <input type="checkbox"/> Spasms/Cramps                  | <input type="checkbox"/> Cancer                   |

Any other health condition(s):.....  
.....

Are you taking any medication? YES ..... / NO.....

If yes please note the medication: .....  
.....  
.....

Which condition/s are you taking medication for:  
.....

Vitamins & Supplements: .....

Are you pregnant? YES ..... / NO ..... / NA .....

Skin Conditions, allergies, sensitivities or other cautions:  
.....  
.....

**Please notify us if you are unable to make your appointment. A fee will be charged if you give less than 24 hours notice of cancellation.**

**Informed Consent to Sport Rehabilitation and Massage at Back-in-Action**

*Before we can start your treatment programme, we need to gain your consent for any procedures we apply.*

<b>I have revealed details on all my past health issues, medical conditions, medications and any history of substance abuse.</b>	<b>Initial:</b>
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<b>I consent to an appropriate physical examination.</b>	<b>Initial:</b>
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<b>I will refrain from the use of recreational drugs or alcohol prior to treatment (i.e. not intoxicated in excess of the Legal Limit for driving).</b>	<b>Yes / No</b>	<b>Initial:</b>
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Therapists using manual therapy techniques are required to inform patients that there are or maybe some rare risks associated with such treatment. Please read your ‘**Informed Consent to Sport Rehabilitation and Massages**’ carefully before your first treatment. If you are satisfied please sign. If you want to, you can discuss any issues with your Therapist before signing.

<b>I have read the “Informed Consent to Sport Rehabilitation, Dry Needling and Massage”. I am aware of the potential risks associated with Sport Rehabilitation, Dry Needling and Massage treatment.</b>	<b>Initial:</b>
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<b>I have had an opportunity, if I wished, to discuss the nature and purpose of the treatment and other procedures in general and my treatment in particular as well as the contents of this consent.</b>	<b>Yes / No</b>	<b>Initial:</b>
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I confirm that I have received and understood the information given to me regarding my case, the proposed treatment and its implications. I understand that results are not guaranteed and that my Therapist has many years of training in diagnosis and treatment. Whilst I understand my Therapist has attempted to give me a complete and accurate description of my complaint and possible risks I do not expect my Therapist to anticipate and explain all the risks and complications of treatment and I wish to rely on my Therapist to exercise best judgement during the course of the procedure which my Therapist feels at the time, based on the facts then known, is in my best interest.

<b>Initial:</b>
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<b>It has been explained to me that I have a contra-indication to treatment but I still wish to continue with this form of therapy and therefore I am signing this statement as a disclaimer.</b>	<b>Yes / No / N/A</b>	<b>Initial:</b>
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<b>If there is a contra-indication requiring GP consent for treatment. Do you give your consent?</b>	<b>Yes / No / N/A</b>	<b>Initial:</b>
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<b>I give my Informed Consent to treatment and understand that at any time I may withdraw my Consent and treatment will be stopped.</b>	<b>Signed:</b>
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<b>From time to time we collect information to prepare an anonymized statistical report for research purposes. I give my consent for my information to be used in these statistical reports.</b>	<b>Yes / No</b>	<b>Signed:</b>
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<b>We may on occasion contact your GP, to let them know what we have found and offer recommendations. Do you give your consent?</b>	<b>Yes / No</b>	<b>Signed:</b>
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<b>I consent for my e-mail address to be used for follow up information about my care and appointment reminders.</b>	<b>Yes / No / NA</b>	<b>Signed:</b>
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<b>I consent for my postal address to be used for follow up information about my care and appointment reminders.</b>	<b>Yes / No</b>	<b>Signed:</b>
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<b>I consent for my mobile number to be used for follow up information about my care and appointment reminders.</b>	<b>Yes / No / NA</b>	<b>Signed:</b>
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<b>I consent to receiving the Clinic Newsletter.</b>	<b>Yes / No</b>	<b>Signed:</b>
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<b>I consent to receiving Clinic Promotions.</b>	<b>Yes / No</b>	<b>Signed:</b>
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### **Privacy Policy Summary**

**Data Protection Act 2018 (GDPR) – Your Personal Information is to be:**

- 1) Processed lawfully, fairly and in a transparent manner
- 2) Collected for specific, explicit and legitimate purposes
- 3) Adequate, relevant and limited to what is necessary
- 4) Accurate and where necessary, kept up to date, with inaccuracies being erased or rectified without delay
- 5) Kept in a form that permits identification of you for no longer than is necessary for the purposes for which your Personal Data is processed
- 6) Processed in a manner that ensures appropriate security of your Personal Data including protection against unauthorized or unlawful processing and against accidental loss, destruction or damage.

Most Registration Forms are stored in the Clinic and the information on the forms and that of those who have requested Articles and / or Newsletters via the Website is entered in the Clinic Software.

The Clinic Software is backed up securely by our Data Processor Software Supplier to third-party Hosting Companies.

We also keep a list of first names and email addresses of patients and those who have requested Articles and / or Newsletters securely on our Website which is managed by another of our Data Processors.

Personal records are only released to third parties if authorized by you in writing or if required by a government agency.

You may choose at any time to have your Email Address Unsubscribed and / or to stop receiving mail or texts by notifying us by email or in writing.

<b>I have read and understand the Summary of the Data Protection / Privacy Policy and consent to my personal data being held by Back-in Action. I am aware I can ask for a paper copy of the full Data Protection / Privacy Policy at any time or see it on the Back-in-Action website.</b>	<b>Signed:</b>
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<b>The content of this form is accurate to the best of my knowledge.</b>	<b>Signed:</b>
	<b>Date:</b>