Patient Personal Record

Identification

Title:	Forename(s):	Surname:
DOB:		
Address:		
Postcode:		

We use this information to identity you and will store your data as per our privacy policy.

Contact details

Home Telephone:	Mobile:	Work:
Email address:		

We use this information to contact you regarding your appointments or to check on your progress.

Occupation:	Place of work:

We use this information in the event you need us to contact your place of work regarding your condition.

Do you give us consent to contact your place of work if we should need to do so

Yes	No

GP name:	GP address:

We use this information in the event you need us to contact your GP regarding your condition.

Do you give us consent to contact your GP if we should need to do so

Yes	No

Emergency contact name:	Contact number:
Relationship to contact:	

We use this information in the event of an emergency.

Reason for attending the clinic:
How did you hear about us:

This information helps us to understand how our patients are referred to us and what patient demographics we commonly see. This information is helpful for clinic marketing and staff training purposes.

Please proceed to page 2

From time to time, the Allsports Therapy would like to get in touch with you to keep you updated on our services, offers and promotions that might be of interested to you.

Consent to contact you via:						
	Phone	Yes	No	Text Message	Yes	No
	Email	Yes	No	Post	Yes	No

IMPORTANT INFORMATION: Please read
Payments are to be made at the end of each session, either by cash, cheque or BACS transfer. Appointments cancelled within 24 hours of the scheduled appointment time may still be charged at half the appointment fee.

By signing below, you agree to the terms and conditions of our privacy policy, which can be found at http://www.allsportstherapy.co.uk/privacy-policy/.

"I hereby consent to being assessed and treated by the practitioner at Allsports Therapy and understand what is required of me as the patient. As the patient, I have the right to refuse any assessment or treatment techniques that I am not clear of or unhappy with."

Patient signature	Date:

(If under 18 years of age, please can the parent/guardian present provide a signature)

THANK YOU FOR COMPLETING THIS FORM. WE WILL STORE THIS SAFELY ALONG WITH YOUR CLINICAL NOTES.