PATIENT NAME : (BLOCK CAPITALS) SURNAME ..... CHRISTIAN NAME .....

THE COPPERHOUSE CLINIC

CONFIDENTIAL PATIENT QUESTIONNAIRE

Podiatry, Chiropractic and Sports Therapy

5 Market Square,
Hayle,
Cornwall
TR27 4EA

T: 01736 757524
E: reception@thecopperhouseclinic.co.uk
www.thecopperhouseclinic.co.uk

General Data Protection Regulation

Who We Are
We are The Copperhouse Clinic, 5 Market Square, Hayle, Cornwall, telephone number 01736 757524. For the purposes of processing your personal data we are the controller.

Data Protection Officer
As we record and use sensitive health data we take the protection of this data very seriously. We have therefore appointed a Data Protection Officer, Sophie Combarel, which is your first point of contact for any matters regarding your personal data we process.

The Personal Data We Process and What We Do With It
We record and use the following categories of personal data: name, address, telephone numbers, email address, date of birth, health information including medical history, diagnosis and treatment data plus payment information. Our lawful basis of processing this data is one of contract and, for the health information, the provision of health-related services as a chiropractic clinic. In addition, we will only examine or treat you with your explicit consent.

Retaining Your Personal Data
Whilst you are receiving treatment from our clinic we will continue to store and use your personal data. Once you have been discharged, we will be required to retain your personal data for a minimum of 8 years.

Your Rights
As we process your personal data, you have certain rights. These are a right of access, a right of rectification, a right of erasure and a right to restrict processing.
You may request a copy of your data at any time. Please make such a request in writing or by email to the Data Protection Officer, whose details are shown above. Please provide the following information: your name, address, telephone number, email address and details of the information you require. We will need to verify your identity, so we may ask for a copy of your passport, driving license and/or recent utility bill.
If you believe any of the personal data we hold on you is inaccurate or incomplete, please contact the clinic directly and any necessary corrections to your data will be made promptly.
If you believe we should erase your data, please contact the Data Protection Officer, whose details are shown above.
If you wish us to stop storing or using your data, please contact the Data Protection Officer, whose details are shown above.

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Data Breaches

Should your personal data that we control be lost, stolen or otherwise breached, where this constitutes a high risk to your rights and freedoms, we will contact you without delay. We will give you the contact details of the Data Protection Officer who is dealing with the breach, explain to you the nature of the breach and the steps we are taking to deal with it.

Should You Wish To Complain

You can contact the ICO via their website: www.ico.org.uk should you wish to make a complaint about the way we are processing your personal data.

Automated Decision Making and Profiling

We do not use any system which uses automated decision making or profiling in respect of your personal data. Our registration number with the Information Commissioners Office is Z393859.
Thank you.

THE COPPERHOUSE CLINIC

Finally, please be aware that the clinic will need 48-hour notice to cancel appointments. Unfortunately, there is a **50% charge** for appointments cancelled within 48 hours.

I consent to The Copperhouse Clinic to keeping my patient records under the terms of The General Data Protection Regulation.

Signed…….. Date……..

Please identify which treatment you consent to receiving;

- ☐ I consent to **Chiropractic** treatment

  Signature…….. Date……..

- ☐ I consent to **Podiatry** treatment

  Signature…….. Date……..

- ☐ I consent to **Sports Therapy** treatment

  Signature…….. Date……..

Signature of accompanying Parent/Guardian if patient Under 16 years:
Signature…….. Name……..
Date……..

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Date……

IT IS **ESSENTIAL** THAT THESE FIRST TWO PAGES ARE COMPLETED IN **FULL**

PERSONAL DETAILS

Surname:	Title: Mr/Mrs/Miss/Dr	Age:
Forename(s):		Date of birth:
Address:	Number of children & ages:	
	Occupation:	Years in job:
	Height:	Weight:
Postcode:	E-mail:	
Tel (home):	Mobile:	Tel (work):
GP's name & address:		
Did your GP refer you? **Yes** / **No** … If not, who referred you?		

CHIEF COMPLAINT & HISTORY

Main complaint:

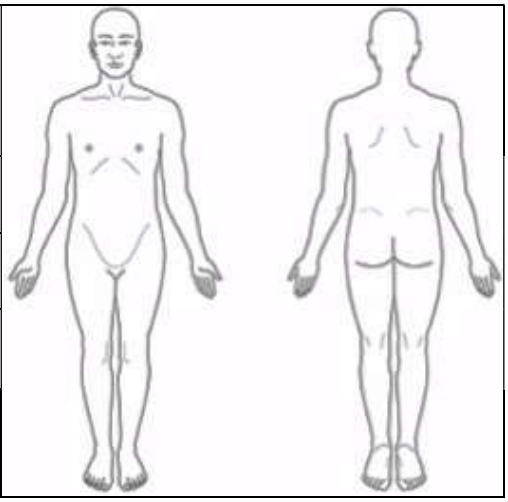
I have felt this way for **DAYS / WEEKS / MONTHS** (circle)
Describe the **character/type** of pain:

On a scale of 1-10 (10 being severe), how bad is your **worst** pain…… and **generally**……..?

Has the complaint got **worse**, stayed the **same**, or got **better** since it started?

What makes it **worse**?……
What makes it **better**?……

Have you had any previous diagnosis or treatment? **Yes** / **No**
If **yes** please give details:

Please shade in areas of the adjacent diagram: Pain with: x Tingling with: o Numbness with: #	
Have you lost weight for no apparent reason? **Yes** / **No**	
Have you had night sweats / pain? **Yes** / **No**	
Have you had any change in bowel or bladder function? **Yes** / **No**	
Any previous tests? (X-rays, MRI, blood tests, urinalysis etc.)	

Do you consider yourself under stress?

If yes	Home	Work
Mild		
Moderate		
Severe		

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MEDICAL DETAILS

Can you please give details of your **general health** e.g. any recent changes, any past or present medical conditions? Are you currently receiving any **medical / NHS** care?

Current Prescribed Medication:

Vitamins/ Supplements / over the counter medicines that you take:

Have **YOU** or any of your **FAMILY** members suffered with any of the following conditions?

	Self	**Family**		**Self**	**Family**
Allergy & skin disorders			Heart disease / Stroke		
Alcoholism			HIV / Hepatitis		
Asthma			IBS		
Blood pressure			Liver and gall bladder disorders		
Cancer			Mental illness		
Diabetes			Osteoporosis		
Epilepsy			Prostate		
Gastro-intestinal disorders			Respiratory disease (lungs)		
Goitre / Thyroid			Rheumatic fever		
Glandular fever			TB		
Headache / Migraine			Urinary tract (kidney/ bladder) disorders		
Hiatus hernia			Other?		

Do you exercise? **Yes / No** If yes what type?.....How often?.....per week

Please give details and the dates of any previous…

- Road traffic accidents:
- Sports or other injuries, including fractures:
- Surgery:
- Major illness:

Do you give your consent for the clinic to contact your GP: **Yes / No**

We will always inform you before doing so.

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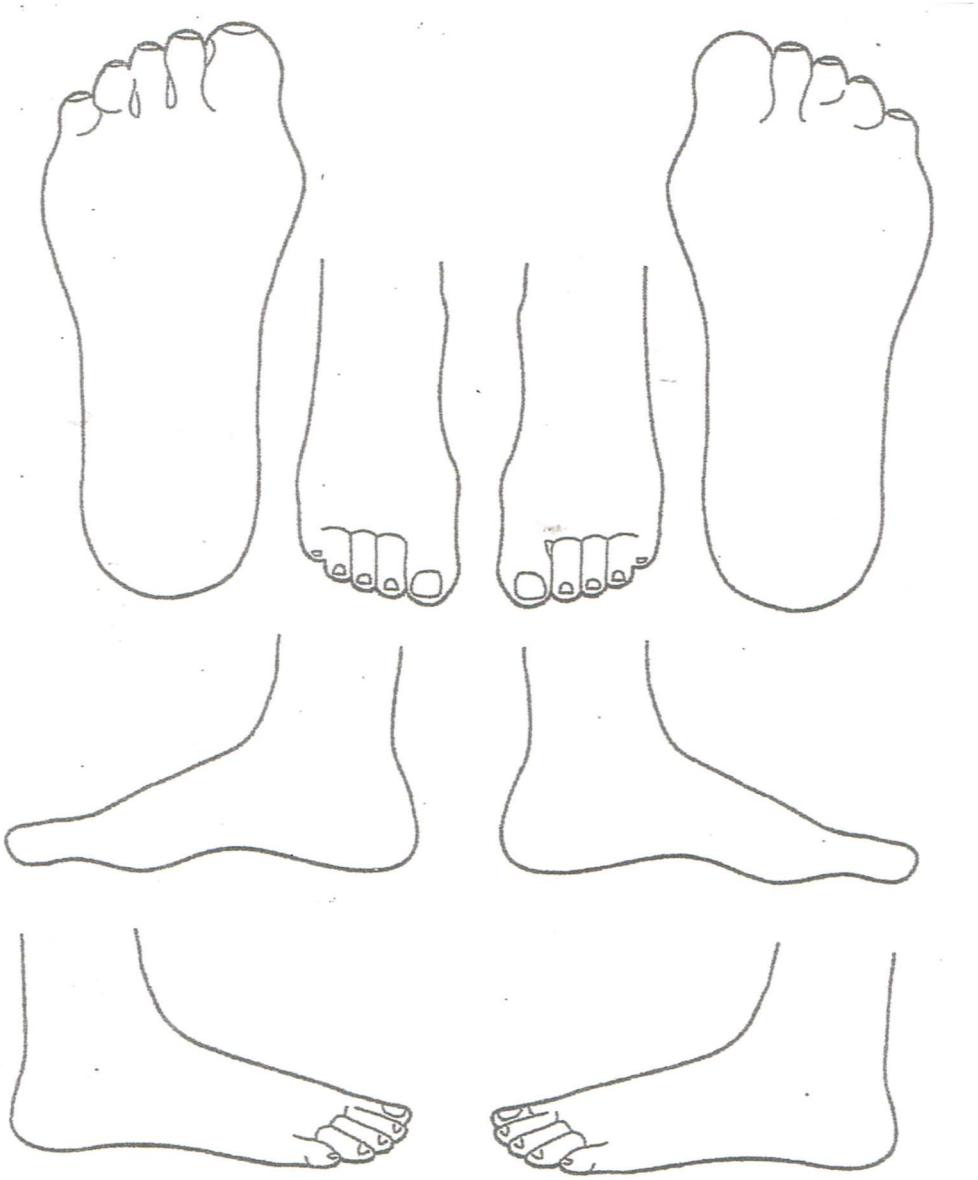
PLEASE CAN YOU MARK THE DIAGRAMS WITH THE LETTER CODING BELOW IN THE BOX ON THE RELEVANT AREA OF THE FEET.

(Callus or hard skin areas for example often indicate biomechanical issues elsewhere in the body. Corns, whatever type are due to excessive referred pressure sometimes even as far up as the lower back.)

Callus #	Corns *	Corns *	Fungal Nail F	Thickened Nail T



My right foot

My left foot