

REGISTRATION FORM



This questionnaire is for your safety and our information. The information is strictly confidential

TITLE	<input type="text"/>	FIRST NAME	<input type="text"/>	LAST NAME	<input type="text"/>	
FULL ADDRESS	<input type="text"/>				POSTCODE	<input type="text"/>
TELEPHONE	W: <input type="text"/>	H: <input type="text"/>	Mobile:	<input type="text"/>		
EMAIL	<input type="text"/>					
DATE OF BIRTH (DD/MM/YY)	<input type="text"/>	<input type="text"/>	<input type="text"/>			
OCCUPATION	<input type="text"/>					
COMPANY	<input type="text"/>					
NAME OF GP	<input type="text"/>					
GP ADDRESS	<input type="text"/>					
CONSULTANT	<input type="text"/>					
HEALTH INSURANCE COMPANY (IF APPROPRIATE)	<input type="text"/>					
POLICY NO	<input type="text"/>	GROUP NO/AUTHORISATION	<input type="text"/>			
HOW DID YOU HEAR OF US? If a colleague, whom?	<input type="text"/>					

MEDICAL CHECK LIST

Have you had any of the following? If yes, please tick

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Cancer | <input type="checkbox"/> HRT | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fractures | <input type="checkbox"/> Long Term steroids |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Gynaecological Problems | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anti Coagulant Therapy | <input type="checkbox"/> Operations | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |

What drugs are you presently taking?

I have been given Back in Action (UK)s Terms and Conditions and by signing this form I confirm that I have read and understood them and agree to abide by them. In summary:

- I understand that I am ultimately responsible for the cost of my treatment.
- Should I fail to attend an appointment without giving 12 hours prior notice then I agree to pay the applicable cancellation/missed appointment fee.
- I consent to treatment by the physiotherapist in attendance
- I agree to have details which are relevant to my condition for which I am now seeking treatment, shared with my GP/consultant.
- I consent to information including medical details about me being processed for the purposes of my treatment as a private patient and the settlement of related expenses.

- Occasionally, Back in Action (UK) would like to email you information about their latest offers and new services. If you DO NOT want to receive such detail please tick here.

Signature: _____ **Date:** _____