RICHARD JONES
PHYSIO
RESTORE • MOVE • THRIVE

# New Patient Registration & Consent Form

*Please complete all sections in full. All information is treated in the strictest confidence and is used only to provide you with safe, effective care.*

## 1. YOUR DETAILS

| Title | First name(s) | Surname |
|---|---|---|
| Date of birth | Preferred name | Pronouns (optional) |

| Home address (including postcode) |
|---|

| Mobile telephone | Home telephone | Email address |
|---|---|---|
| Occupation | NHS number (if known) | How did you hear about us? |

## 2. YOUR GP DETAILS

We may need to contact your GP in relation to your care. We will only do so with your consent (see Section 10), unless there is an immediate risk to your safety.

| GP name | GP practice name |
|---|---|
| GP practice address (including postcode) | GP practice telephone |

## 3. EMERGENCY CONTACT

| Full name | Relationship to you | Telephone number |
|---|---|---|

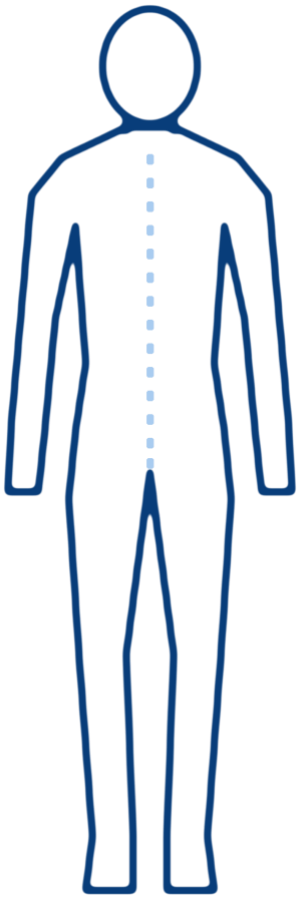
## 4. REASON FOR YOUR VISIT

| Please describe your current problem, including when and how it started |
|---|
| |

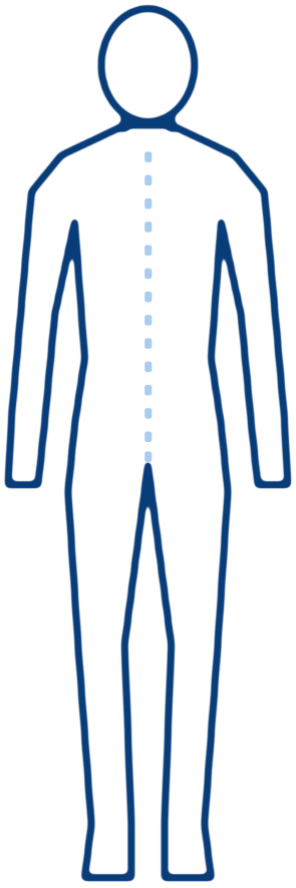
| Is this related to an accident, injury or insurance claim? If yes, please give details | Have you had physiotherapy for this problem before? If yes, where and when? |
|---|---|
| | |

## 5. BODY MAP & SYMPTOM DESCRIPTION

Please mark on the diagrams below where you feel your symptoms, using the key. Mark every area that troubles you, even if it seems unrelated — patterns matter.



FRONT



BACK

**KEY**

X X Sharp / stabbing

//// Aching

··· Pins & needles

O O Numbness

~~~ Burning

S Stiffness

| Pain at its WORST (0 = none, 10 = worst imaginable): /10 | Pain at its BEST: /10 | Pain RIGHT NOW: /10 |
|---|---|---|
| | | |
~~~

| What makes your symptoms worse? | What makes your symptoms better? |
| --- | --- |
| | |

| Notes on areas of pain (e.g. when it started in each area, how it has spread or changed) |
| --- |
| |

| Areas of improvement (anything already getting better, and progress noted during treatment — reviewed with your physiotherapist at each visit) |
| --- |
| |

## 6. MEDICAL HISTORY

Please tick Yes or No for each item. This helps us make sure your treatment is safe and appropriate. If you answer Yes, please give brief details.

| | Yes | No | Details |
|---|---|---|---|
| Heart problems, high blood pressure or circulatory conditions | ☐ | ☐ | |
| Respiratory conditions (e.g. asthma, COPD) | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Epilepsy, seizures, blackouts or dizziness | ☐ | ☐ | |
| Stroke or neurological conditions | ☐ | ☐ | |
| Cancer (current or previous) | ☐ | ☐ | |
| Osteoporosis or low bone density | ☐ | ☐ | |
| Rheumatoid arthritis or other inflammatory joint disease | ☐ | ☐ | |
| Recent unexplained weight loss | ☐ | ☐ | |
| Recent surgery or hospital admissions (last 12 months) | ☐ | ☐ | |
| Fractures, joint replacements or metal implants | ☐ | ☐ | |
| Skin conditions, open wounds or infections | ☐ | ☐ | |
| Bladder or bowel problems, including any recent changes | ☐ | ☐ | |
| Pregnancy (current or within the last 12 months) | ☐ | ☐ | |
| Any other medical condition we should know about | ☐ | ☐ | |

| **Current medications (including dosage, if known)** | **Allergies (medication, latex, plasters, oils, chlorine, etc.)** |
|---|---|
| | |

## 7. HYDROTHERAPY (AQUATIC PHYSIOTHERAPY) SCREENING

*Complete this section only if you may receive hydrotherapy as part of your treatment. Some conditions require additional precautions in a pool environment.*

| | Yes | No | Details |
|---|---|---|---|
| Do you have any fear of water, or are you unable to swim? | ☐ | ☐ | |

| | Yes | No | Details |
|---|---|---|---|
| Do you have any open wounds, sores, ulcers or unhealed scars? | ☐ | ☐ | |
| Do you currently have any infection (chest, urine, skin, ear or eye)? | ☐ | ☐ | |
| Do you have incontinence of bladder or bowel? | ☐ | ☐ | |
| Do you have epilepsy or a history of seizures? | ☐ | ☐ | |
| Do you have a tracheostomy, catheter, stoma or PEG feed? | ☐ | ☐ | |
| Are you sensitive or allergic to chlorine or pool chemicals? | ☐ | ☐ | |
| Have you had diarrhoea or vomiting in the last 14 days? | ☐ | ☐ | |
| Do you have uncontrolled blood pressure, angina or breathlessness at rest? | ☐ | ☐ | |

## 8. ACUPUNCTURE / DRY NEEDLING SCREENING & WRITTEN CONSENT

*Complete this section only if acupuncture or dry needling may form part of your physiotherapy treatment. Because needles pierce the skin, Richard will review this screening with you before treatment and obtain specific informed consent.*

| | Yes | No | Details |
|---|---|---|---|
| Do you have a bleeding or clotting disorder, or do you bruise or bleed easily? | ☐ | ☐ | |
| Are you taking anticoagulant or antiplatelet medicines (for example warfarin, apixaban, rivaroxaban, dabigatran, edoxaban, clopidogrel or prescribed aspirin)? | ☐ | ☐ | |
| Are you pregnant, trying to become pregnant, or could you be pregnant? | ☐ | ☐ | |
| Do you have a pacemaker, implanted electrical device or other implanted medical device? | ☐ | ☐ | |
| Have you ever fainted, felt unwell or had a severe fear/reaction around needles or blood? | ☐ | ☐ | |
| Do you have epilepsy, seizures, blackouts or unexplained loss of consciousness? | ☐ | ☐ | |
| Do you have diabetes, poor circulation, impaired sensation or problems with wound healing? | ☐ | ☐ | |
| Do you have a weakened immune system, take immunosuppressant medication, or have a condition that may increase infection risk? | ☐ | ☐ | |
| Do you currently have a fever, infection, skin infection, rash, open wound or broken skin in or near the proposed treatment area? | ☐ | ☐ | |

| | Yes | No | Details |
|---|---|---|---|
| Do you have lymphoedema, or have you had lymph nodes removed in the area that may be treated? | ☐ | ☐ | |
| Do you have any allergy or sensitivity to metals, latex, plasters, adhesives, skin-cleaning products or other materials used during treatment? | ☐ | ☐ | |
| Have you previously had acupuncture or dry needling and experienced an adverse reaction or complication? | ☐ | ☐ | |
| Is there anything else about your health, medication or previous treatment that you think Richard should know before acupuncture/dry needling? | ☐ | ☐ | |

*Important: A "Yes" answer does not automatically mean acupuncture/dry needling cannot be used. It means Richard will assess the individual risk, discuss appropriate precautions or alternatives, and may defer treatment or seek further medical information where clinically appropriate.*

## ACUPUNCTURE / DRY NEEDLING - SPECIFIC WRITTEN CONSENT

I understand that acupuncture/dry needling involves the insertion of sterile, single-use needles through the skin as part of physiotherapy treatment. Richard has explained why it is being considered, the expected benefits, reasonable alternatives (including choosing not to have needling), and the material risks relevant to me.

I understand that common or expected effects can include temporary soreness, aching, minor bleeding or bruising, tiredness, dizziness or fainting, and a short-term increase in symptoms. Less common risks include infection or an unexpected reaction. Where treatment is near the chest or upper back, needling can carry a rare but serious risk of pneumothorax (collapsed lung) or injury to underlying structures.

I understand that I can ask questions, decline any needle or treatment area, ask for treatment to stop, or withdraw consent at any time without affecting the rest of my care.

☐ I confirm that I have answered the acupuncture/dry needling screening questions accurately and will tell Richard about any change in my health, pregnancy status, medication or bleeding risk before future sessions.

☐ I have had the opportunity to ask questions and I give my explicit written consent to acupuncture/dry needling when clinically appropriate and explained to me.

**Patient signature:** _____ **Print name:** _____ **Date:** _____

### CLINICIAN / INSURANCE SAFEGUARD - COMPLETE BEFORE FIRST NEEDLING SESSION

- ☐ Screening reviewed; indications, precautions and contraindications assessed and documented in the clinical record.
- ☐ Material risks, benefits and reasonable alternatives discussed; treatment site(s) and technique recorded; explicit consent reconfirmed for this session.
- ☐ Current professional indemnity/PLI and scope of practice checked for the proposed technique and anatomical area. If relying on the CSP PLI scheme, acupuncture for fertility problems and thoracic acupuncture are excluded from that scheme and must not be undertaken under that cover. Any activity outside the applicable policy must have separate confirmed indemnity before treatment.
- ☐ Any applicable local-authority registration/licensing requirements for skin-piercing acupuncture/dry needling have been met.

**Clinician initials:** _____ **Date:** _____ **Relevant precautions / action taken:** _____

## 9. CONSENT TO ASSESSMENT AND TREATMENT

Physiotherapy assessment and treatment may involve physical examination, hands-on treatment (including manual therapy and soft tissue techniques), exercise prescription, electrotherapy, hydrotherapy and, where clinically appropriate, acupuncture/dry needling. Acupuncture/dry needling will only be undertaken after the specific screening and written consent in Section 8 have been completed. Your physiotherapist will explain the nature, purpose, expected benefits, reasonable alternatives and any material risks of the proposed assessment and treatment before it begins, and will answer any questions you have.

You may be asked to remove some clothing so the affected area can be properly assessed. You are welcome to bring a friend, relative or chaperone to any appointment, and you may request one at any time.

Consent is ongoing: you may ask questions, decline any part of treatment, or withdraw your consent at any time without giving a reason and without it affecting your care.

- ☐ I confirm that the information I have given on this form is accurate and complete to the best of my knowledge, and I will inform the practice of any changes to my health or medication.
- ☐ I consent to physiotherapy assessment and treatment as explained to me. I understand I can withdraw my consent at any time.

## 10. HOW WE USE YOUR INFORMATION (PRIVACY NOTICE)

Richard Jones Physio is the data controller for the personal information you provide on this form. We collect and process your personal and health information in order to provide you with safe and effective physiotherapy care, to maintain accurate clinical records, and to meet our legal and professional obligations. Our lawful bases for doing so under UK GDPR are the provision of health

care (Article 9(2)(h)) and our legitimate interests in running the practice, alongside your consent where required.

Your records are stored securely and retained in line with UK health record retention guidance (normally 8 years after your last appointment for adults, or until a child's 25th birthday). Your information will never be sold or used for third-party marketing. You have the right to access your records, request corrections, and complain to the Information Commissioner's Office (ico.org.uk). Full details are available in our privacy policy, available on request and at richardjonesphysio.co.uk.

☐ I confirm I have read and understood how my information will be used.

☐ I consent to Richard Jones Physio contacting my GP or other healthcare professionals involved in my care, where relevant to my treatment. *(optional)*

☐ I consent to receiving appointment reminders by SMS / email. *(optional)*

☐ I would like to receive occasional news and health information from the practice by email. I can unsubscribe at any time. *(optional)*

## 11. APPOINTMENTS AND CANCELLATIONS

We ask for at least 24 hours' notice if you need to cancel or rearrange an appointment. Appointments cancelled with less than 24 hours' notice, or missed without notice, may be charged at the full appointment fee. We will always be understanding of genuine emergencies.

☐ I have read and accept the cancellation policy.

## 12. DECLARATION

| Signature (patient) | Print name | Date |
|---|---|---|
| | | |

*For patients under 16, or adults who lack capacity to consent, this form must be completed and signed by a person with parental responsibility or an appropriate legal representative, who should also state their relationship to the patient.*

| Signature (parent / guardian / representative) | Print name & relationship | Date |
|---|---|---|
| | | |

**FOR OFFICE USE ONLY**

Form checked by: _____ Date: _____ Patient ID: _____



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Chartered Physiotherapist · Registered with the Health and Care Professions Council (HCPC) and the Chartered Society of Physiotherapy (CSP)