Personal Details	
Name	
Date of Birth	
Address	
Phone number	
Email address	
Doctor Name	
Doctor Address	
Sporting Activity	

How did you hear about us? (Please tick)			
Online		Facebook	
Poster		Leaflet	
Friend/Family/Colleague		Email	
Kent Sport Staff		University Staff	
Event:10k/VCCup/Pilgrims		Fitness Suite	
Other:		Canterbury Hockey	

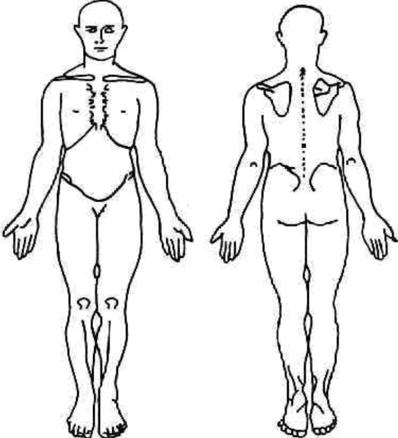
Medical Details					
Please highlight any of the following which you have/ have had in the past:					
	YES/NO		YES/NO		YES/NO
Unexplained weight loss		Bilateral Pins and Needles in feet		Fatigue	
History of cancer		Unsteady with walking		Fibromyalgia	
Diabetes		Bladder/Bowel problems		Hernia	
Epilepsy		Saddle Anaesthesia		Hepatitis	
Asthma		Inability to lie flat		Tuberculosis	
Heart problems/Stroke		Facial/Tongue pins and needles/numbness		Are you currently pregnant?	
Raised blood pressure		Nausea		Kidney disease	
Anxiety/Depression		Shortness of breath		Use of orthotics	
Any other conditions/comments from YES with dates and descriptions					

Orthopaedic Conditions					
	YES/NO		YES/NO		YES/NO
Arthritis		Limited joint range		Joint replacement	
Broken bones		Scoliosis		Slipped discs	
Sprains/Strains		Congenital hip dislocations		Dislocated/subluxed joints	
Any other conditions/comments from YES with dates and descriptions					

Have you had any investigations/treatments/medication linked to your current injury? E.g. MRI, X-Ray

Have you had any investigations/treatments/medication linked to your previous injury? E.g. MRI

Body Chart



Description of current injury

DATA PROTECTION STATEMENT

Your consultations at the **Kent Sports Clinic** are treated as confidential as far as is permitted by the General Data Protection Regulation (EU) 2016/679 (“GDPR”) and Data Protection Act 1998. We are registered with the Information Commissioner’s Office as a Data Controller (Reg No.Z6847902).

As part of our treatment of you, we are required by law to make a record of your care with us. You have a right to see these records if you wish. We are required to store your records for a legally determined period after your treatment with us has finished. Generally, adult records will be stored for 7 years, and children’s (persons under 18 years of age) records will be stored until they are 26 years old. Records may be stored for longer for other patient groups. Once the retention period has expired, the records will be securely and permanently destroyed. Records will be stored electronically and paper details will be destroyed after inputting onto the system.

We may need to share some of the information you give us, or that we find through examination, with other health professionals in order to give you the best available advice and treatment. We will always seek to ensure that you are aware of the communication we have with other health professionals before communication commences. You have the right to prevent us sharing information. If you expressly forbid us from sharing information with other health professionals directly involved in your care, then it may prevent us from giving you the most appropriate care, and in extreme cases may mean we cannot treat you.

We do not share your information with third parties (such as solicitors or employers) without obtaining your written permission beforehand. We will tell you who is asking for the information, what they are asking for, and what they need the information for. You can choose whether you give us written permission. If you do not give your permission, then it may prevent us from helping others to assist you, and in extreme cases may mean we cannot treat you.

There are certain limited circumstances in which the law requires us to share information with others, even if you tell us not to.

If you have any concerns about how we collect, store or use the information we hold about you, please talk to us about your concerns and we will be happy to discuss it with you.

PRE-QUALIFIED APPOINTMENTS

I acknowledge that the hands-on care and advice I am to receive whilst at the Kent Sports Clinic will solely be performed by a student therapist currently studying BSc (Hons) Sports Therapy & Rehabilitation at the University of Kent, under supervision from a qualified practitioner.

I understand the student(s) are supervised by a qualified practitioner and I have the right to express any concerns to the supervisor without fear of offending or scrutiny.

I am able to ask any questions to the student(s) and/or supervisor and I am allowed to provide detailed feedback to the student(s) to ensure I am happy with my care. Lastly, I have the right to decline any care I do not wish to receive.

PATIENT CONSENT INFORMATION

I agree in giving my consent to be assessed and treated by the Kent Sports Clinic Team. I am aware these assessments and treatments may involve being asked to remove clothing that is appropriate to my injury site.

I am also aware that I may be asked to be videoed in order to provide key information for walking, running or sporting movement as part of the assessment. However I will always be asked for my consent to do this and understand any footage used will not be shared and will be deleted after my treatment has finished.

I realise that refusal to give my consent to these types of assessments and treatments will not affect any further access to medical care from the Kent Sports Clinic.

The Kent Sports Clinic and Kent Sport may contact you with follow up emails, offers and promotions. At no point will we sell or share your details with third parties.

Please note you may be charged the full amount of your appointment if you fail to give 24 hours' notice of your cancellation.

AUTHORISATION

The information below will be stored securely in accordance with the General Data Protection Regulation (EU) 2016/679 ("GDPR") and Data Protection Act (1998).

I ______________________________ , Date of Birth ______________________________

(PRINT NAME)

☐ I give consent for you to contact me.

☐ I have read and understood the notes on **informed consent** and fully understand them.

☐ I have read and understood the **Data Protection Statement**.

☐ Pre-qualified appointments: I confirm my understanding and consent to student Sports Therapy & Rehabilitation services.

Signed ______________________________

Date ______________________________

COVID-19 DECLARATION FORM

TESTING				
Have you had a Covid-19 test? If yes, when? Antigen or antibody test? **Antigen** – tests for Covid-19 on day of testing. **Antibody** – possible immunity	YES Date:		NO	
If it was a positive result, has the isolation period expired?	YES		NO	
Do you still have symptoms?	YES		NO	
Are you registered with the a Test & Trace app?	YES		NO	
SYMPTOMS - Are you experiencing any of the following?				
Severe breathing difficulties or chest pain	YES		NO	
Difficulty in waking or confusion	YES		NO	
If yes to any of the above call 999				
Fever	YES		NO	
Onset, or worsening of a cough	YES		NO	
Sore throat or runny nose	YES		NO	
Chills or headache	YES		NO	
Pain swallowing	YES		NO	
Muscle & joint ache	YES		NO	
Fatigue or exhaustion	YES		NO	
Loss of taste or smell	YES		NO	
If any of the above, the advice is to self-isolate for 7 days. A Covid-19 test may be necessary, call 119				
Shortness of breath or difficulty lying down due to chest issues	YES		NO	

If any of the above, call 111

Have you been in contact with anyone with Covid-19 symptoms?	YES	NO
Have you recently been hospitalised?	YES	NO
If so, why:		
Do you have any of the following health issues		
High blood pressure or other heart condition	YES	NO
Diabetes Type 1 or 2 – if so, which?	YES	NO
Cancer	YES	NO
Lung condition	YES	NO
Any other conditions – please list:		
If you have had Covid-19:		
Are you experiencing post Covid-19 circulatory complications (deep vein thrombosis, micro-embolisms, stroke symptoms or pulmonary embolism)	YES	NO
Are you?		
An NHS front line worker	YES	NO
A carer – home or care home	YES	NO
Shielding a vulnerable adult	YES	NO
Pregnant – how many weeks?	YES	NO
Aged over 70	YES	NO
Allergic to latex gloves or specific cleaning products	YES	NO

SIGNED

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.

If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Test & Trace I will inform you.

Full name: ....

Date: ....

Please return this form to sportsclinic@kent.ac.uk before your appointment

ISSUED AUGUST 2020