PATIENT FORM

We have helped many people with a variety of symptoms/problems and we like to be aware of all the health improvements you experience when you come to see us

STAFF USE ONLY

NAME

Nº.

DOB

PLEASE INDICATE THE CONDITIONS / SYMPTOMS YOU HAVE HAD OR DO HAVE...

✓ EXAMPLE

- ○ HEADACHES
- ○ INSOMNIA
- ○ LOW ENERGY / FATIGUE
- ○ POOR CONCENTRATION
- ○ BRAIN FOG
- ○ ANXIETY
- ○ DIZZINESS
- ○ LOW RESISTANCE TO DISEASE
- ○ EARACHE

- ○ HAYFEVER
- ○ HEARING PROBLEMS

- ○ SINUS PROBLEMS
- ○ VISUAL PROBLEMS

- ○ SLUGGISHNESS
- ○ NIGHTMARES

- ○ DIFFICULT TO TAKE A DEEP BREATH
- ○ SHORTNESS OF BREATH

- ○ ASTHMA
- ○ BREATHING DIFFICULTIES

- ○ HIGH / LOW BLOOD PRESSURE
- ○ HEART CONDITIONS

- ○ INDIGESTION
- ○ HEARTBURN
- ○ ACID REFLUX
- ○ BELCHING
- ○ TROUBLE WITH FATTY FOODS

- ○ BLOATING
- ○ FLATULENCE
- ○ CONSTIPATION
- ○ DIARRHOEA
- ○ IBS
- ○ ABDOMINAL CRAMPS

- ○ KIDNEY INFECTION
- ○ BLADDER INFECTION
- ○ SWOLLEN ANKLES

- ○ PMT
- ○ PERIOD PAIN
- ○ PROSTATE PROBLEMS

- ○ LEG PAIN
- ○ PINS & NEEDLES
- ○ CRAMP IN LEGS
- ○ SWOLLEN ANKLES
- ○ REPRODUCTIVE PROBLEMS

PERSONAL DETAILS:

First Name: _____ Surname: _____ Sex: _____

Marital Status: _____ Date Of Birth: _____ Age: _____

Occupation: _____ Height: _____ Weight: _____

Address: _____

_____ Post Code: _____

Tel (home): _____ Tel (work): _____

Tel (mobile): _____

GP's Name & Address: _____

_____

How did you hear about us? ○ Existing Patient Who may we thank for referring you to us? _____

○ Advert ○ Our Website ○ Passing Clinic ○ Other _____

Do you have private medical insurance? ○ yes ○ no Which Company? _____

WEBSITE MEMBERSHIP

The information on our website will help you GET WELL and STAY WELL. Please provide the following details so we can establish you as a member of our website today.

Email Address: _____

Please tick the health subjects that most interest you: please tick as many as you like

- ○ Headaches and Neck Pain
- ○ Backaches and Sciatica
- ○ Children's Health Issues
- ○ Women's Health Issues
- ○ Wellness Topics
- ○ Diet and Nutrition
- ○ Exercise and Fitness
- ○ Stress Management

By joining our website, you authorise us to send occasional health care related emails to you. You may opt out at any time. Please make sure you have entered your email address above.

MAIN REASON FOR VISIT: (i.e. low back pain, headaches, leg pain etc) _____

When did it start? _____

HOW DID IT START?
- ○ Accident
- ○ Bending / twisting
- ○ Gradually
- ○ Lifting
- ○ No cause
- ○ Not sure
- ○ Sports
- ○ Suddenly
- ○ Woke with it
- ○ Other

TYPE OF PAIN
- ○ Ache
- ○ Burning
- ○ Dull
- ○ Numbness
- ○ Pins and needles
- ○ Sharp
- ○ Stabbing
- ○ Weakness
- ○ Other

WHAT MAKES IT WORSE
- ○ Bending
- ○ Cold / damp weather
- ○ Driving
- ○ End of the day
- ○ Heat
- ○ Rest
- ○ Lifting
- ○ Mornings
- ○ Rising from seated
- ○ Prolonged sitting
- ○ Prolonged standing
- ○ Walking
- ○ Other

WHAT MAKES IT BETTER
- ○ Heat (wheat bag or bath)
- ○ Ice
- ○ Keeping busy / movement
- ○ Massage
- ○ Painkillers
- ○ Rest
- ○ Other

IS IT...
- ○ Constant
- ○ Intermittent
- ○ Up and down
- ○ Good / bad days
- ○ Getting worse
- ○ Getting better
- ○ Staying the same

RATE YOUR PAIN ON A SCALE OF 0 - 10...
(0 = no pain, 10 = worst pain possible)

If 'Other' ticked at any point, please specify further: _____

What is the pain stopping you from doing? (e.g. work, playing golf, walking, lifting the grandkids etc.) _____

_____

Have you had treatment for this or similar problems? ○ yes ○ no Please give details: _____

WOULD YOU LIKE US TO LOOK AT ANY OTHER PROBLEMS OF CONCERN? (i.e. low back pain, headaches, leg pain etc) _____

_____ When did it start? _____

HOW DID IT START?
- ○ Accident
- ○ Bending / twisting
- ○ Gradually
- ○ Lifting
- ○ No cause
- ○ Not sure
- ○ Sports
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THE FOLLOWING QUESTIONS ARE ABOUT YOUR GENERAL HEALTH: Please complete where applicable.

Do you currently smoke? ○ yes ○ no

Have you ever smoked? ○ yes ○ no When did you stop? _____

Do you drink alcohol? ○ yes ○ no How many units per week? ○ 0-10 ○ 11-21 ○ 22+

Do you take regular exercise? ○ yes ○ no What activities? _____

Do you have children? ○ yes ○ no Ages? _____

Are you pregnant? ○ yes ○ no

When was your last period? _____

HAVE YOU HAD OR DO YOU HAVE:

- ○ Allergies
- ○ Ankle swelling
- ○ Cancer
- ○ Constipation
- ○ Difficulty breathing
- ○ Eczema / skin problems
- ○ Grinding teeth
- ○ High blood pressure
- ○ Joint swelling
- ○ Loss of vision
- ○ Palpitations
- ○ Prostate problems
- ○ Teeth removed
- ○ Anxiety / stress disorder
- ○ Angina
- ○ Chest pains
- ○ Cystitis
- ○ Difficulty urinating
- ○ Epilepsy / seizures
- ○ Headaches
- ○ Indigestion / acid reflux
- ○ Loss of balance
- ○ Low blood pressure
- ○ Period pains
- ○ Rapid weight loss
- ○ Varicose veins
- ○ Arthritis
- ○ Bladder infections
- ○ Cold sweats
- ○ Diabetes
- ○ Dizziness
- ○ Eye problems
- ○ Heart attack(s)
- ○ Irregular periods
- ○ Loss of consciousness
- ○ Numbness
- ○ Pins and needles
- ○ Sinus problems
- ○ Visual disturbances
- ○ Asthma
- ○ Bloating / gas
- ○ Chronic thrush
- ○ Diarrhoea
- ○ Eating disorder
- ○ Fatigue / tiredness
- ○ Hearing problems
- ○ Jaw pain / clicking
- ○ Loss of taste / smell
- ○ Orthodontic work
- ○ PMT
- ○ Stroke / TIA

Have you ever had X-rays or MRI scans? ○ yes ○ no Please give details including dates: _____

_____

Are you currently attending hospital or seeing a specialist? ○ yes ○ no Please give details: _____

_____

THE FOLLOWING QUESTIONS ARE ABOUT YOUR GENERAL HEALTH: Continued.

Do you take any form of medication? ◯ yes ◯ no If yes, please detail below:

Drug Name:	Reason for taking:	Date started:

Have you had any surgery? ◯ yes ◯ no If yes, please detail below:

Surgical procedure:	Date of surgery:

Have you ever been involved in any accidents? Car, motorbike, pushbike, ladders, falls, slips, trips etc. ◯ yes ◯ no If yes, please detail:

Type of accident:	Date of accident:	Injuries (broken bones / unconsciousness etc):

Has anyone in your immediate family ever suffered from: Cancer, Hepatitis, Diabetes, Tuberculosis, Epilepsy, Rheumatoid Arthritis or Stroke?

◯ yes ◯ no Please give details: _____

How long has it been since you last felt your best? ◯ years ◯ months ◯ weeks ◯ days

On a scale of 1 to 10 (1 being poor, 10 being excellent) please describe your: Eating habits _____ Exercise habits _____

Sleep pattern _____ General health _____ Mind set _____ Posture _____ Energy levels _____ Happiness _____

Do you want to ..? ◯ Improve your health ◯ Get pain relief ◯ Both

PLEASE SIGN TO GIVE THE CHIROPRACTOR PERMISSION TO EXAMINE YOU.

I, the undersigned, understand that a physical examination is required to determine my condition and I hereby give my consent to the chiropractic examination.

SIGNED _____ PATIENT / PARENT / GUARDIAN DATE _____

THANK YOU FOR COMPLETING THE FORM. PLEASE RETURN TO THE RECEPTIONIST (do not fill out below until after your consultation)

PLEASE SIGN TO GIVE THE CHIROPRACTOR PERMISSION TO TREAT YOU.

I, the undersigned, confirm that I have received and understood the information given to me regarding my presenting health complaint, the proposed treatment and its implications. I understand that the chiropractor(s) will use their skills to improve my condition where possible. I hereby give my consent to treatment of the full spine and extremities for the purpose of improving my health status and/or for the relief of symptoms.

SIGNED: _____ PATIENT / PARENT / GUARDIAN DATE: _____

PLEASE SIGN TO GIVE PERMISSION FOR THE RELEASE OF MEDICAL NOTES.

I, the undersigned, give the chiropractor permission to release my medical notes or detail their contents to the persons named below.

NAME: _____ ADDRESS: _____

SIGNED: _____ PATIENT / PARENT / GUARDIAN DATE: _____

DATA PROTECTION DISCLAIMER: All information provided will be kept in the strictest confidence and in accordance with the Data Protection Act. We will not share information with any third party without your consent.

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