Tel: 021-4824450
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Eastcliffe House, Glanmire, Cork
E-mail: info@wellspringchiropractic.ie

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date of Birth:**
Address:	
Mobile phone:	**Home/Work phone:**
Occupation:	**G.P.:**
No. of children:	**Pregnant?** Yes ☐ No ☐
Height:	**Weight:**
Marital status:	**Spouse/guardian name:**

****E-mail address:** _____

**In the coming days you will receive a link to subscribe and once you do you will receive great tips and how-to's in our monthly newsletter and special offers & discounts for our clinic.

Who may we thank for referring you? If your GP/Consultant referred, you please let us know

_____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms (Please explain):

_____

_____

Which activities aggravate your condition?

_____

_____

What Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well-being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following?

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays/scans taken?

Area of body:	When?	Where?
Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain)

_____

_____

STRESSORS (VERY IMPORTANT TO FIGURE OUT HOW THIS HAS HAPPENED TO YOU)

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. **Physical stress** (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. **Bio-chemical stress** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. **Psychological or mental/emotional stress** (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (including physical (Pain), bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

Please Tell Us Your Biggest Goal of Attending here? What do you want to return to or be able to do again?

_____

_____

CONSENT TO HOLD FILE AND DATA PROTECTION POLICY

Pursuant to the Data Protection Act 2018, we are required to advise patients of our Data Protection Policy.

POLICY

As part of a patient's records, this Clinic retains information for the purposes of consultation for treatment, recording treatments and payments and use by Dr Eric Kelly and third-party payers such as health insurance companies.

All paper files and information contained within a patient's records may be electronically scanned and stored on computer file for as long as the relevant patient remains a patient of this Clinic, and for a period of at least 8 years thereafter. Paper records will be retained for the same period.

All information held both in paper and electronic formats will be accessible only by the staff of this Clinic who are directly involved in the data entry and processing of patient records. Other than for the purposes stated here, information will not be released except with the patient's written consent, or as required by law. To see our privacy policy please go to www.wellspringchiropractic.ie

CONSENT

I hereby acknowledge that I have read the above Data Protection Policy and hereby give consent to the maintenance of my records for the purposes outlined within said Policy.

Signed _____ **Date** _____

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

CONSENT TO PHYSICAL EXAMINATION

I consent to physical examination by my Chiropractor, to include (as needed) foot examination and Gaitscan.

Signed _____ **Date** _____

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

CONSENT TO CONTACT YOUR HEALTHCARE PROVIDER

I hereby authorize you to contact my Healthcare Providers to obtain reports and/or information pertaining to myself and to write to him/her following my treatment.

Signed _____ **Date** _____

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

ONLY SIGN BELOW AFTER TALKING TO THE DOCTOR

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The chiropractor, _____, has explained his/her opinion/assessment of my condition and prognosis to me. He/she also explained the relevant treatment options that are available to me and the associated risks, including in his/ her opinion the potential negative outcome/s or risks of <u>not</u> having the treatment.

The explanation, including potential risks and benefits that are specific to me I fully understand. I have had the opportunity to discuss and clarify any concerns with the chiropractor. For example, the possible risks of cauda equina syndrome, stroke, fracture, post treatment pain and agitating preexisting conditions.

I understand that the result/outcome of the treatment cannot be guaranteed. I also understand that I can seek another opinion as to my condition/treatment if I desire to do so before I commence treatment.

Having fully understood all of this and having fully considered my options I consent to receive the treatment I have discussed with my Chiropractor and/or anyone authorized by him/her.

CONSENT

Signed _____ **Date** _____

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

Witness _____ **Date** _____