CONFIDENTIAL PATIENT INFORMATION

(For office use) **Date:** **Patient Code:**	**Cobham Chiropractic Centre** **Tel: 01932 988580** E-mail: reception@cobhamcc.co.uk www.cobhamcc.co.uk

Personal Information

Full name:	**Mr / Mrs / Miss / Ms** (please circle)
Address (including postcode):	
Home phone:	**Work phone:**
Mobile phone:	**Email address:**
Date of birth:	**Age:**
No. of children: **Ages:**	**Pregnant?** **No ☐** **Yes ☐** **no. of weeks:**
No. of grandchildren:	
Height (cm):	**Weight (kg):**
Marital status: **M** **S** **W** **D**	**Spouse/guardian name:**
Occupation:	
Employer's name:	

Who may we thank for referring you? _____

What Has Brought You Here?

Main area of complaint (describe any symptoms you may have): _____

_____

_____

Mark your level of pain on this scale:

Mild				Moderate				Severe	
1	2	3	4	5	6	7	8	9	10

When did it start? _____

What do you think has caused it? _____

Has it happened before? ***Yes / No*** When? _____

Any pain or other symptoms elsewhere? (please list everything) _____

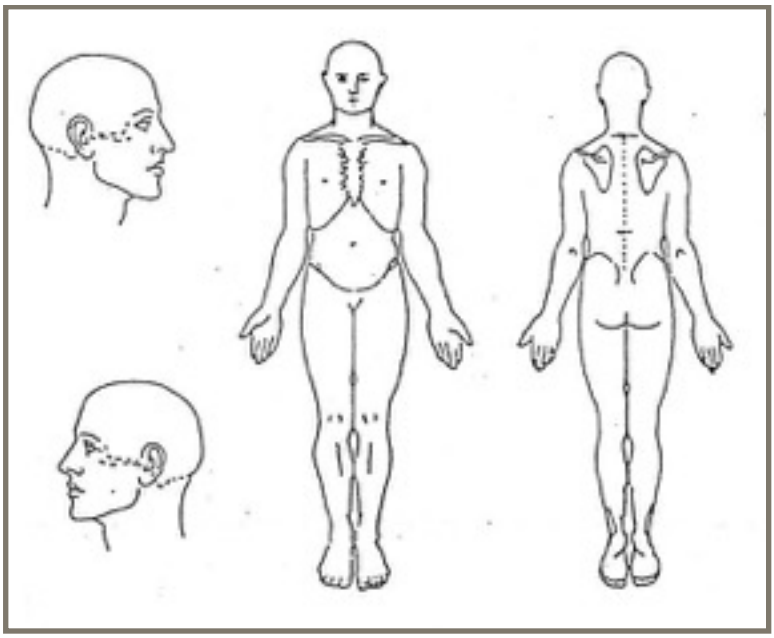
_____

_____

How is this problem affecting your life? (e.g. what does it stop you from doing?) _____

_____

Please mark on this diagram all areas of pain / symptoms:



Please circle your answers to these questions below, where 1 is poor and 10 is the maximum:
I rate the flexibility of my neck:
1 2 3 4 5 6 7 8 9 10
I rate the flexibility of my lower back:
1 2 3 4 5 6 7 8 9 10
I rate my posture:
1 2 3 4 5 6 7 8 9 10
My energy/vitality levels are:
1 2 3 4 5 6 7 8 9 10

Past history: (Please give dates where appropriate)

Surgery - please list any/all, or state 'none': _____

_____

_____

Accidents - e.g. car, bike, horse, fall, fracture: _____

_____

_____

Stressful events - e.g. divorce, separation, bereavement: _____

_____

Any ongoing stresses - e.g. work, relationships, finances: _____

Are you taking any medication or other drugs? Please list: _____

_____

What are you hoping for from Chiropractic care? _____

_____

I declare that the above information is true and correct to the best of my knowledge. In accordance with the Data Protection Act (1998), all information provided will be treated as confidential, and will not be given to any other persons or organisations without written consent of the patient concerned.

Signature: _____ **Date:** _____

Patient Consent

As part of our professional responsibility, we require you to please read the following carefully and then sign each section.

PATIENT NAME: _____

DATE OF BIRTH: _____

CONSENT TO EXAMINATION

I consent to an appropriate physical examination by the Chiropractor.

Signed: _____ Date: _____

(If under 16 years of age, this consent should be signed by a parent or legal guardian.)

CONSENT TO X-RAY EXAMINATION

If indicated, and after having been informed of the clinical need for an appropriate x-ray examination, I consent to this procedure. I, to the best of my knowledge, am not pregnant. I do not know of any other reason why this procedure should not be undertaken at present.

Signed: _____ Date: _____

(If under 16 years of age, this consent should be signed by a parent or legal guardian.)

X-RAY HOLDING POLICY

Cobham Chiropractic Centre have a legal obligation to keep on file any X-rays ordered by us for a period of eight years. The X-rays are taken for chiropractic diagnostic purposes and remain the property of the practice in accordance with the General Chiropractic Council legislation. If a patient requires them for any reason, e.g. a consultation with another health professional, an X-ray Release Form needs to be signed.

Signed: _____ Date: _____

(If under 16 years of age, this consent should be signed by a parent or legal guardian.)

CONSENT TO TREATMENT

I understand that the purpose of chiropractic is not to treat symptoms or conditions, but rather to correct the function of the spine and nervous system to allow the body to heal and repair that which ails it. I understand that I will receive a full verbal explanation of findings from the Chiropractor, together with a proposed plan if my case is accepted for care. By subsequently receiving my first adjustment, I consent to care, accept any risk involved and understand that successful outcomes cannot be guaranteed.

Signed: _____ Date: _____

(If under 16 years of age, this consent should be signed by a parent or legal guardian.)