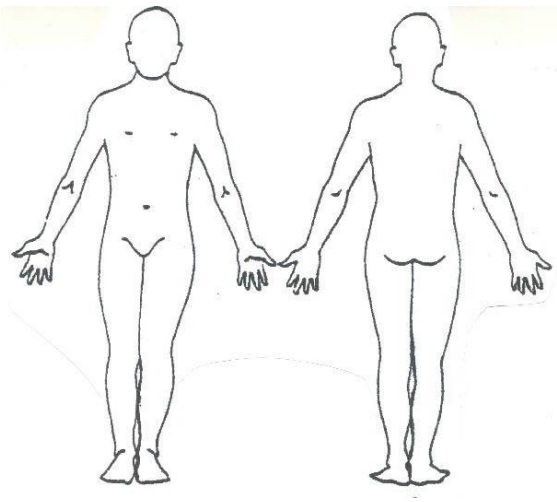
CONFIDENTIAL PATIENT INFORMATION

Surname:		First Name:
Address:		Town:
Birth Date: / /		Email:
		Post code:
Home Ph:	Work Ph:	Mob Ph:
Occupation:		Employed by:
Type of work: ☐Sitting ☐Computer ☐standing ☐driving ☐lifting ☐other: _____		
Marital Status:		Partner's name:
Children's names & ages:		
How did you hear the practice?		

What is the reason for your visit today? _____

_____

Please mark on the diagram where you are experiencing the problem.



When did this problem begin? _____

Was it: ☐Sudden onset ☐Gradual onset ☐result from accident

What do you think caused it? _____

Is the pain: ☐Sharp ☐Dull/Achy ☐Burning ☐Numbness ☐ Tingling

☐Stabbing ☐Shooting ☐Stiffness ☐Tightness ☐ Tension

What aggravates your condition? _____

_____

What relieves your condition? _____

_____

Have you had this Pain before? ☐No ☐Yes: _____

Have you seen anyone about this Problem? Who and When: _____

Do you have any other complaints? ☐No ☐Yes. If Yes please list below.

1. _____ How long for? _____
2. _____ How long for? _____

Please tick if you have had any of the following:

☐ Frequent colds / infections	☐ Poor concentration	☐ Headaches/ Migraines	☐ Arthritis
☐ Cold hands / feet	☐ Low energy fatigue	☐ Menstrual pain / irregularity	☐ Osteoporosis
☐ Digestive problems	☐ Bladder problems	☐ Hot flushes / fevers	☐ Heart disease
☐ Anxiety / Nervousness	☐ Irritability	☐ Allergies	☐ Stroke
☐ Ulcers	☐ Depression	☐ Mood swings	☐ Diabetes
☐ High blood pressure	☐ Low pain threshold	☐ Seizures / fainting	☐ Respiratory problems
☐ Low back pain	☐ Neck pain	☐ Dizziness	☐ Cancer

Please list the doctors who you consulted for these conditions:

1. _____ Diagnosis given: _____

2. _____ Diagnosis given: _____

3. _____ Diagnosis given: _____

Have you ever been to a Chiropractor before? □ Yes □ No If yes, when? _____

Name and address of current GP:_____

Date of last physical: ____ / ____ / ____

Please list any operations you have had (and ages):

1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had (and ages):

1. _____ 2. _____ 3. _____

Please list any traumas, accidents, broken bones or injuries you have had (and ages):

1. _____ 2. _____ 3. _____

Are you currently taking medication (including the contraceptive pill)? If yes, what type and what for?

_____

Do you smoke? □ Yes □ No If yes, how many per day? _____ for how many years?_____

Do you drink tea or coffee? □ Yes □ No If yes, how many cups per day? _____

How many glsses of water do you drink per day? _____

Females Only: Is there any possibility that you are pregnant? □ Yes □ No Date of last period: ___ / ___ / ____

In general, would you say your health is: (please circle): Excellent Very Good Good Fair Poor

In general, how would you rate your energy levels: (please circle): Excellent Very Good Good Fair Poor

How would you rate your current level of stress? (please circle): Very High High Moderate Low Very Low

How would you describe your posture? (e.g. hunched, normal, weak, lop-sided)_____

Has any blood relative (not including your spouse) had any of the following. If yes, please specify (who, what, when):

□ Bone or Joint disease (Arthritis / Osteoporosis) _____
□ Vascular disease (Heart disease / Stroke / Blood Pressure) _____
□ Cancer (Benign / Malignant) _____
□ Respiratory problems (Lung / Chest / Asthma) _____
□ Digestive problems (Stomach / Bowel) _____
□ Reproductive problems _____
□ Diabetes / Metabolic disorders _____
□ Epilepsy / Nervous system disorders _____
□ Skin disorders _____
□ Allergies _____
□ Other _____

What would you like to achieve/what are your health goals?_____

_____

Is there anything else you would like us to know?_____

DECLARATION: This information is accurate to the best of my knowledge.

PATIENT SIGNATURE:…….. DATE: …… / …… / ……

CHIROPRACTOR SIGNATURE:…….. DATE: …… / …… / ……..