CHIROPRACTIC FIRST

Personal Details

First Name: | Surname: | Sex:

Marital Status: | Date of Birth: | Age:

Occupation: | Height: | Weight:

Address:

Postcode:

Tel (Home): | Tel (Mob):

Email: | GP:

How did you hear about us?: ☐ Advert ☐ Our Website ☐ Passing Clinic ☐ Existing Patient, if so..

Who may we thank for referring you to us?

Do you have private medical insurance:

Main Reason for visit:

☐ Low back pain ☐ Neck Pain ☐ Headaches ☐ Other

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
- ☐ Lifting
- ☐ Cold / damp weather
- ☐ Driving
- ☐ End of the day
- ☐ Heat
- ☐ Rest
- ☐ Mornings
- ☐ Rising from seated
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Walking
- ☐ Other

What makes it better
- ☐ Heat (wheat bag or bath)
- ☐ Ice
- ☐ Keeping busy / movement
- ☐ Rest
- ☐ Massage
- ☐ Painkillers
- ☐ Other

Is it...
- ☐ Constant
- ☐ Intermittent
- ☐ Up and down
- ☐ Getting worse
- ☐ Getting better
- ☐ Staying the same

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

Rate your pain on a scale of 1-10 (please circle relevant number)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

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?

Habits:

Smoking	Cigarettes/day
Alcohol	Units/week
Coffee/Tea	Cups/day
Soft Drinks	Glasses/day
Water	Glasses/day

Exercise:

Type

- ☐ None
- ☐ 1-2 days/week
- ☐ 3-4 days/week
- ☐ +5 days/week

Patient Number

Name

Have you currently or previously experienced?

	Yes	No		Yes	No		Yes	No
Abdominal discomfort			Difficulty concentrating			Loss of taste / smell		
Allergies			Difficulty sleeping			Loss of weight without trying		
Anxiety or nervousness			Dizziness			Night sweats		
Bloating or gas			Ear infections			Numbness		
Breathing difficulties			Epilepsy			Palpitations		
Chest pains			Grinding teeth			Period pains		
Chronic thrush			Headaches			Pins and needles		
Constipation			Heart attack			Prone to cold/cough		
Cramp			High blood pressure			Ringing in your ears		
Diabetes			History of cancer			Sinus Problems		
Diarrhoea			History of stroke			Tiredness		
Difficulty in urinating			Indigestion			Visual disturbances		

Do you take any form of medication? If yes, please detail below:

Have you had any surgery? If yes, please detail below:

Surgical Procedure Date

Have you ever been involved in any accidents? Car, motorbike, pushbike, ladders, falls, slips, trips etc. If yes, please detail:

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

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: