Chiropractic Clinic *Dr.* *Date:*

PATIENT TO COMPLETE

PERSONAL DETAILS – please print clearly

Surname:……………………………………………………………Title …………Age:….………………..

Forename(s):………………………………………………………. Date of Birth……………………………

Full Address:………………………………………………………………………………………………...

……………………………………………………………………………………Post Code:…………………..

Home telephone (incl. code):…………………………Work telephone (incl. code):……….…………………

Mobile…………………..………. email: ………………………………………………...

Marital Status:………………(optional) Weight:…………………. Height…………………………

Number and Ages of Children:………………………………………………………………….(optional)

How did you hear about us? Personal referral, Yellow pages, Walk By, Internet, Talk, Promotion / Advert

………

Do you have medical insurance? YES / NO Which company?…………………………………………….

Will you be making a claim on the above OR is this part of an insurance or legal claim? YES / NO

Occupation:……………………….. .. Sedentary or Active? …………….. Year in current job ………………

HEALTH DETAILS

GP Surgery:……………………………………… Name of GP: ……………………………………………..

Last seen?…………… Current conditions under medical treatment/management? ……………………………

Prescribed medication being taken/was taking? ……… Non-prescribed?……………………...

…………………………………………………………… ………………………………………..

………………………………………………………….. ………………………………………..

Have you ever broken any bones in the past? ………… How & when?……………………………………...

Any Road Traffic or other accidents? ………….. How & when?……………………………………...

Any Operations/Hospitalisation? ……………… How & when?……………………………………...

Any previous imaging (X-rays, MRI, scans) + body area (e.g. chest)…………………….. (Date)……………….

How much do you smoke? ……… Have you ever smoked? ……………..Quit ………………………………

How much alcohol do you drink? ..……Units per week (½pint/ 250ml wine/ single shot = 1 unit)

Do you drink **at least** 2 litres of fluid (water) daily?……Special diet?(vegetarian, allergenic)………………………

Do you take regular exercise? ………What activities? ……………………………How often?......................

Where are you in your menstrual cycle / with relation to the menopause? ……………………………………..

Do you perform regular self breast examination? ....… ..Last cervical smear? ………………………………...

Do you perform regular testicle self examinations? …… Last prostate exam? ………………………………..

Have you lost or gained weight? ……………………..

Had other medical attention/treatment recently? ……….. Details:………………………………………………...

Any other health care? (complementary, traditional, ethnic, non-medical):……………………………………...

TURN OVER

SYSTEMS REVIEW – please circle current or recurring problems & supply info &/or time frames

E.g: Big Toe **Swollen** (circled) - *Gout - since last week*

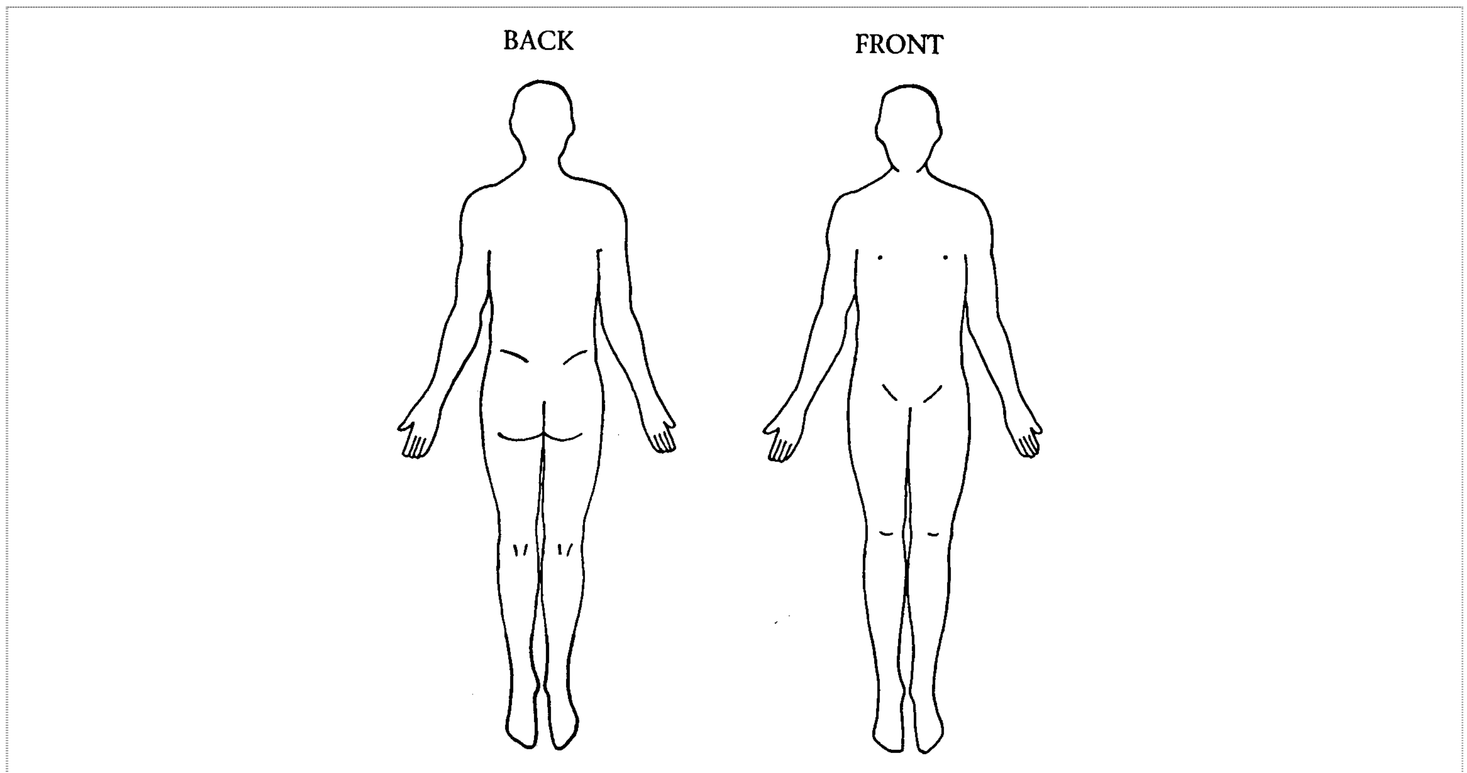
General	Fatigue / run down	Weight Loss	Fever	Chills	Sweats	Diet changes	
Skin	Allergy	Rashes	Itching	Sores	Hives	Tumours	Moles
Head	Pain	Stiffness	Injury	Infections			
Neck	Pain	Stiffness	Injury	Infections			
Eyes	Glasses	Itching	Infection	Redness	Pain	Vision changes	
Ears	Hearing	Infection	Pain	Tinnitus	Vertigo		
Nose/Sinuses	Discharge	Infection	Blood	Pain	Smell	Blockage	
Mouth/Throat	Pain	Dryness	Hoarseness	Swallowing	Teeth &Gums	Infection	Dentures
Respiratory	Cough	Sputum	Pain	Difficulty breathing	Asthma		
Breasts	Lumps	Pain	Tender	Bleeding	Infection	Discharge	
Heart	Angina (pain on exercising)	Blood pressure	Valves (murmur)	Arrhythmia (heart flutters)	Disease	Cholesterol	
Vascular	Claudication (Calf / leg pain with walking)	Varicose veins	Ulcers	Arteries	Raynauds	Lymph	
Gastro-intestinal	Nausea	Vomiting	Heartburn	Tend to diarrhoea	Tend to constipation	Irritable Bowel (IBS)	Inflammatory disease
Organs	Liver	Gall Bladder	Pancreas	Spleen	Kidneys	Adrenals	
Urinary	Pain on urination	Blood in urine	Incontinence / loss of control	Get up at night to urinate	Infection / cystitis	Stones	Have “to go” often
Gynaecological	Bleeding	Discharge	Itching	Contraception	Menopause	Endometriosis	
Male genital	Pain	Swelling	Discharge	Infection			
Musculoskeletal	Arthritis	Gout	Pain	Swelling	Sciatica	Pins & needles	Disc damage / Pinched nerves
Neurological	Epilepsy	Stroke	Faints / loss of consciousness	Arm or Leg Weakness	Co-ordination	MS	Numbness
Blood	Anaemia	Bruise easily	Bleeding disorder				
Endocrine / Hormonal	Diabetes	Weight loss	Weight gain	Thyroid	Fluid intake		
Immune	Allergy	Asthma	Frequent colds / flu	HIV			
Mental	Anxiety	Depression	Mood Swings	Unenthusiastic	Irritable	Can’t Sleep	Always Tired

* DO YOU HAVE ANY OTHER **SPECIAL HEALTH MATTER/SPECIFIC QUESTION(S)** NOT COVERED HERE THAT YOU WISH TO RAISE WITH THIS CLINIC OR FEEL SHOULD BE BROUGHT TO YOUR CHIROPRACTOR'S ATTENTION? ………

………..

Family history	Please state if any near family members have suffered any of the following		
	Family member	condition	caused disability or death
- Heart disease			
- Stroke			
- Cancer			
- Spinal problems			
- Other			
-			
-			
-			

Please indicate where you experience your symptoms



Please mark the severity / intensity of your Main Complaint. cross (X) at worst Circle (O) at easiest										
0	1	2	3	4	5	6	7	8	9	10

CONSENT TO EXAMINATION

I consent to an appropriate physical examination by the chiropractor.

Signed____ Date_____________________

Under 16 years of age? This consent MUST be countersigned by a parent or legal guardian.