



Dear Patient - Chiropractic is a primary health-care profession that specialises in the diagnosis, treatment and overall management of conditions that are due to problems with the joints, ligaments, tendons and nerves, especially related to the spine. To enable us to provide you with our best possible health care it is necessary for you to fill in this registration and health questionnaire carefully and fully. **Thank you.**

PERSONAL DETAILS

Date:

Surname: Forename(s): Title:

Date of birth: Age:

Address(incl. Post Code):.....

Home no(incl. Area Code): Mobile no: Work no:

E-mail address: Occupation:

Marital Status: Number of children: Age of children:

Your height: Your weight: Who referred you to us?

Do you have medical insurance? Yes[] No[] Which company?.....

Are you currently in a relevant legal claim? If so, please detail:

Your GP's name & address:

YOUR CONDITION

Please mark your main complaint(s): Lower back[] Upper back[] Neck pain[] Head ache[]

Other:

List any minor complaint:

Does the pain/discomfort radiate to other areas? Leg[] Arm[] Head[] Other:

When did it first start?

Was it a sudden or gradual onset?

How many episodes have you had? How often?

Does the pain change with activity/movement or is it constant?

Was there an accident or cause of this condition? Please explain:

What is the quality of the condition? Burning[] Tingling[] Aching[] Stabbing[] Numb[],

Other:

What makes it better? What makes it worse?

When is it the worst? am[] pm[] evening[] at night[]

Does the pain wake you from a sound sleep? Yes[] No[]



YOUR CONDITION – Continued: On a scale of 0-10 in which box would you put your pain level for your primary complaint?

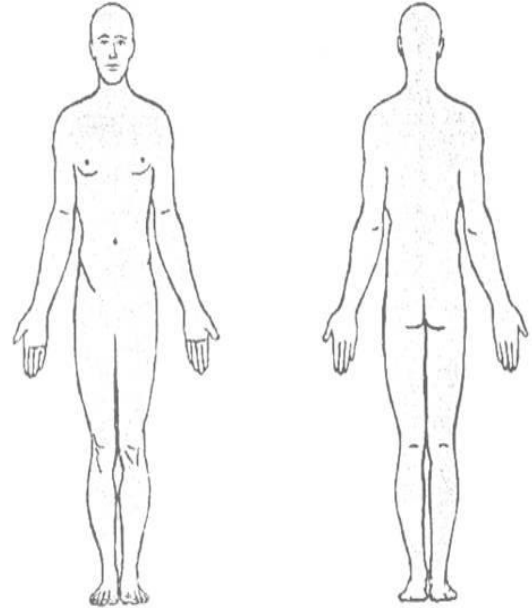
X at worst **O** at best = if both the same

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10(max.pain)

Please draw on the bodies where your pain is and mark the type of pain using the letters:

- | | |
|---------------------------|-----------------------------|
| CP = Constant Pain | P = Pain |
| R = Redness | S = Swelling |
| T = Tenderness | L = Limited movement |



What other specialist have you seen for this condition?

Specialist:

Treatment:

Result:

What test(s) have you had for this condition? X-rays[] CT[] MRI[] Blood[] Urine[]

Other:

YOURS AND YOUR FAMILY GENERAL MEDICAL HISTORY

Surgeries / Hospitalisation?

Major illness / Accidents?

Any medication taken at present?

Do you have any other symptoms or health problems?

Are you seeing any other doctor or specialist for any reason?



WORK AND SOCIAL HISTORY

Please circle what daily regular activities you perform at work/home: Bending[] Lifting[] Sitting[]
Driving[] Other:.....

Leisure/Sport/Hobby activities?

Smoker? Yes[] No[] per day.....

Drinker? Yes[] No[] units per week.....

Additional space for your comments:
.....
.....

GENERAL HEALTH CONDITION

Have you or any of your family members suffered with any of the following problems/conditions?

Problem	Self	Immediate family	Description	Age
Liver/kidney				
Heart/Stroke				
Lung/breathing				
Digestion				
Bowel				
Bladder				
Reproductive				
Circulation				
Diabetes				
Cancer				
Epilepsy/nervousness				
Allergy/skin				
Blood pressure				
Migraines/headaches				
Dizziness				
Tinnitus				
Ears/eyes/nose/throat				
Arthritis/orthopaedic				
Multiple sclerosis				
Loss of consciousness				
Dental, speech, jaw				
Irritability, nervous ,depression				



Chest pain				
Abdominal pain				
Blood discharge				
Sudden weight loss/gain				
Skin				
Broken bones				

GENERAL

It is the clinic policy that we contact your GP with our findings.

Do you give your consent to this? Yes[] No[]

(Females) Could you be pregnant? Yes[] No[]

I consent to X-rays if required Yes[] No[]

Are you interested in chiropractic care
of your general health? Yes[] No[]

I consent to important treatment information being e-mailed to me and understand that I can stop this at any time Yes[] No[]

CONSENT TO EXAMINATION

During the consultation your chiropractor will need to perform various orthopaedic and chiropractic tests together with a physical examination of your problem area in order to establish whether we can help you or not.

Do you consent to this examination? Yes[] No[]

CONSENT TO TREATMENT (To be signed by yourself AFTER the consultation)

I have received adequate information regarding my chiropractic care and proposed treatment. I can confirm that, to the best of my capabilities, I understand this explanation and agree to both treatment and that any X-rays taken will remain the property of the clinic but will be released to other qualified practitioners on their request.

Signed.....Dated.....

You have been of great assistance to us by completing this form. Thank you. When you are happy there is nothing more you wish to add to your history, could we please ask you to sign and date the form and bring it with you to the consultation.

Signed and Dated.....