**Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**Mr/Mrs/Miss/Ms**

**Surname:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_

**First names:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tel No Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Postcode:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Can we email you?** Yes ( ) No( )

**Name and Address of GP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we contact your GP If we need to?** Yes/No

Married ( ) Partnered ( ) Single ( ) Divorced ( ) Widow/er ( ) Number of Children: \_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?**

Social Network( ) Newspaper( ) Appointment Card Ad( ) Internet( ) John O’Gaunt Golf club ( )
Groupon Voucher( ) Doctor Referral( ) Advertisement Signs( ) Recommended( ) BUPA( )
Complimentary Referral( ) Beds Life Mag( ) Walk-in( ) Complimentary Network( ) Bartercard( ) Gift Voucher ( ) Harpur Centre ( ) **Please tell us the name of the person who recommended you so we can thank them:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Area of complaint (can be more than one)**

Check up only( ) Neck( ) Shoulders ( ) Elbow ( ) Hand( ) Upper back( ) Mid Back ( ) Lower back( ) Hips( ) Knees( ) Arm ( ) Leg( ) Ankles ( )Feet( ) Other please specify: \_\_\_\_\_\_\_\_\_\_\_\_ **Also:** Dizziness ( ) Headaches ( ) Sinus Issues ( ) Bloating ( ) Constipation ( ) Poor Sleep ( ) Low Energy ( ) Migraines ( ) Other please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your complaint a result of an accident?** Yes( ) No( )

**What is the worst your pain get to (0 – No pain, 10- Unbearable)** 1 2 3 4 5 6 7 8 9 10 **(please circle)**

|  |  |  |
| --- | --- | --- |
| **Does this cause you to be:** | **Does this affect your work:** | **Does this affect your life:** |
| Moody | Decision Making | Lose patience with your family |
| Irritable | Poor attitude | Restricted household duties |
| Interrupt sleep | Decreased Productivity | Cant exercise or play sport |
| Restrict your daily activities | Exhausted at the end of the day | Interference with hobbies/activities |

 **How long have you been putting up with it?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you think caused the problem?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Have you had any previous treatment with any of the professions below?** Yes ( ) No Chiropractor ( ) Osteopath ( ) Physiotherapy ( ) Other ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **What was your response?** Excellent ( ) Good ( ) Fair ( ) Poor ( ) No Change ( )

**Previous conditions and Family Health**

**Have you had any operations or suffered from cancer or any other medical conditions?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you broken any bones, or been in a trauma, e.g. a car accident/fall/knock/injury? Please specify where sustained and when it occurred.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are there any conditions in your family history (e.g. heart disease, circulation problems, diabetes, cancer, rheumatoid arthritis, Osteo- arthritis, back, neck pain, scoliosis or osteoporosis?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any medication?** Yes ( ) No ( )

 (If yes please name the medication and the reason you have to take them) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you Smoke?** Yes ( ) No ( )

**Do you drink alcohol?** Yes ( ) No ( ) How often?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What regular exercise do you do?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there any further information you would like to tell the Chiropractic Doctor?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please Circle**

**On a scale of 1-10 where would you put your health now? (1 worst – 10 best)** 1 2 3 4 5 6 7 8 9 10 **Where would you like your health to be at?** 1 2 3 4 5 6 7 8 9 10 **What do you think is a reasonable time span for you to achieve this?** Years:\_\_\_ Months:\_\_\_ Weeks: \_\_\_

**What are you most interested in improving?**

Overall Health ( ) Less pain/ Symptoms ( ) Reducing Stress ( ) Increasing your Energy and Vitality ( )

**What would you like to be able to do that you cannot do now?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List your desired health goals and the areas you are most interested in improving**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT**

***The Chiropractic Dr will always strive to do the best for you and is available to answer and queries you may have relating to your care, in person or on the telephone.***

***I confirm that I agree to appropriate physical examination and any necessary treatment regardless of the outcome. I understand that the information, written or otherwise, is given in the strictest confidence. No information or patient records will be released to any person, insurance company or the other doctor without my consent.***

***Patient or Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***