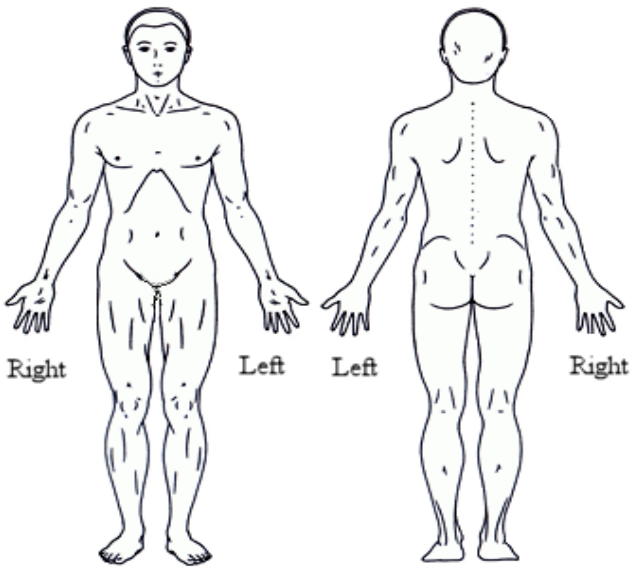
SWADLINCOTE
CHIROPRACTIC CLINIC

Personal Information		
Mr / Ms / Mrs / Dr / Prof First Name(s)	Surname	
Address		Postcode
Birth Date Occupation (or previous if retired)	Age	
Married / Single / Partnered / Widowed	Email	
Home phone	Mobile	Work
G.P. name / address		
How did you hear about our clinic		

Medical History
How would you describe your general health? Excellent 1 2 3 4 5 Very Bad
Height Weight
Do you smoke Y / N do you drink Y / N if yes how many units a week?
Have you ever had a serious illness?
Have you ever had any breathing problems?
Have you ever had any urinary complaints?
Do you suffer from headaches or migraines?
Have you seen your G.P. in the last 6 months?
Are you taking any medication, including supplementation Y / N (the chiropractor will discuss this further)
Have you had any operations, including major dental work? Please give dates
Have any of your family members suffered any serious illnesses? (i.e. cancer; stroke; heart attack; diabetes; neurological problems; arthritis etc.)
Females only; Are you pregnant Y / N or Is there any chance you could be Y / N

Presenting Complaint
What is your main complaint
Do you know the mechanism / cause of injury?
Was the onset; Sudden / Gradual / Woke with pain the next day
How long have you had this problem

Have you ever had anything similar before Y / N when?
Do your symptoms radiate into the arms / legs, fingers / toes
Please describe your pain – Dull – Sharp – Aching – Stiffness – shooting – Burning – Tingling – Numbness - Other (describe)
Are your symptoms; – Constant – Come & Go –Weekly – Monthly - Improving - Worsening – the same since onset – Other(Describe)
Your general pain level is – No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain
Does anything make the symptoms worse
What makes the symptoms better – Meds – Heat – Cold – Movement – Rest - Other
Are your symptoms worse at a particular time of day; if so when
Does the pain affect any of your normal daily activities Y / N



Please indicate on the diagram the location and character of your pain / discomfort:

- Numbness ====
- Tingling oooo
- Dull / Achy pain vvvv
- Sharp pain / / / /
- Burning xxxx
- Stiffness ####

Presenting complaint (Continued)
Does your GP know about this condition Y / N
What other treatments have you received for this problem
Where? When?
Did it help? Y / N / not sure. How many treatments did you have?
Any Investigations Y / N X-Ray / MRI / CT / Bone Scan / Blood Tests / Other Where and when What were the results?
Is your condition work related YES NO MAYBE
Have you had any accidents or injuries that may have caused or contributed to your problem?
Does your pain stop you from getting to sleep? Y / N
Do you wake in the night due to pain? Y / N If yes; how often? Any particular time?
Do you suffer from night sweats that are not due to hormonal changes Y / N
Have you had any recent, unexplained weight loss? Y / N
Have you had any unexplained change in your bowel or bladder function Y / N
Helping this issue would increase my quality of life by: 10-20% 30-40% 50-60% 70-80% 90% 100%

Insurance Information

Do you have private health insurance? YES NO

If yes name of provider:

Examination

I consent to an appropriate examination

Signed: …… Date: ……

Treatment

(Do not complete this section until the chiropractor has discussed your clinical findings with you. If chiropractic care is deemed unsuitable for you there will be no charge for our service, and you will be referred to the appropriate healthcare professional.)

I hereby request and consent to the performance of chiropractic treatment, including various physical therapy, of me by Colin Evans and/or anyone working in this clinic authorised by Colin Evans.

I have had the opportunity to discuss with the chiropractor the nature and purpose of the chiropractic treatment and other procedures, as well as any potential risks that my current health status may predispose me to. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some potential risk factors. I do not expect the chiropractor to be able to anticipate and explain all risks and complications and I wish to rely on the Chiropractor to exercise judgement during the course of the procedure which the Chiropractor feels at the time, based upon the facts then known, and is in my best interests.

Signed:

…… Date: ……

(Patient)

Signed:

……

(Chiropractor)

CHILD CONSENT

I hereby give my consent for my child……to be treated by the chiropractor, using chiropractic methods as seen fit.

Parent/Guardian: ……(Print Name)

Signed: ……(Signature)

Date: ……