Shoreham Chiropractic Clinic

# Welcome to Shoreham Chiropractic Clinic

Your chiropractor will be with you shortly. Please take your time in completing this questionnaire as the information you provide here will help the chiropractor in understanding your condition. For us to decide whether your problem is suitable for chiropractic care, we must assess all the aspects of your current health status. If you require any help please ask at reception.

Name: ............................................................
Address: ............................................................
............................................................
Postcode: ............................................................
Landline: ............................................................
Mobile: ............................................................
Can we send you reminders via text? ☐ Yes ☐ No
Email: ............................................................
Can we send you our newsletter via email? ☐ Yes ☐ No
Occupation: ............................................................
Years in job: ................ yrs

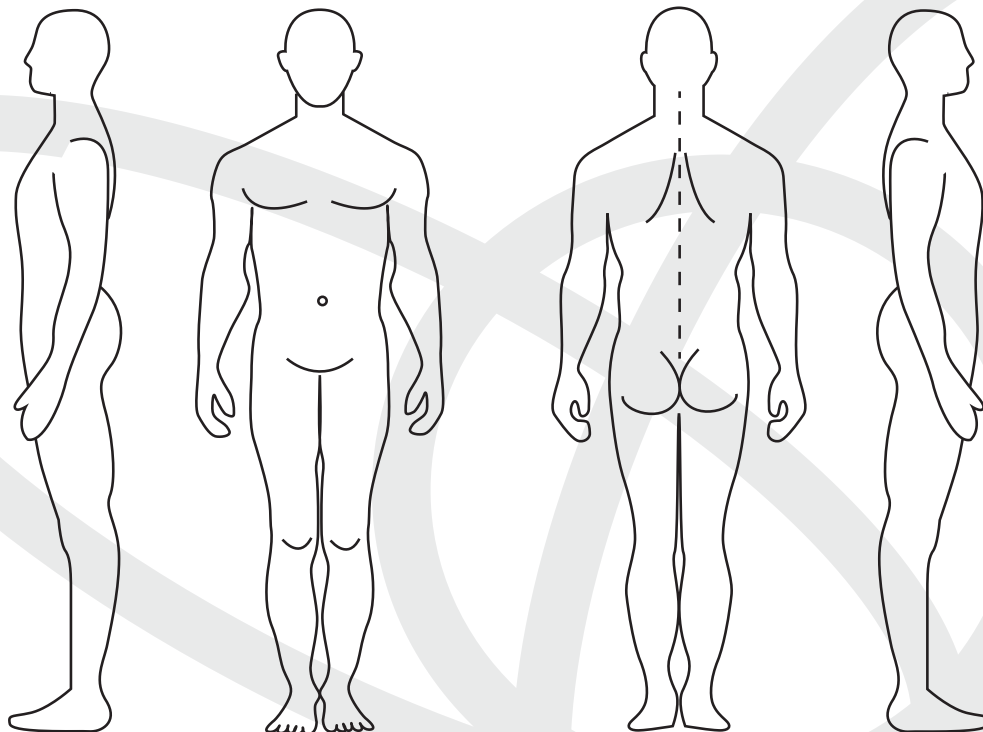
Date of Birth: ....... /....... / ....... Age: ..............................
Marital Status: ............................................................
No. of Children: ............................................................
Childrens Ages: ............................................................
GP Name: ............................................................
Surgery: ............................................................
It is clinic policy that we contact your GP.
Do you give your consent? ☐ Yes ☐ No
Do you have medical insurance? ☐ Yes ☐ No
Will you be claiming your fees? ☐ Yes ☐ No
Insurance company ............................................................

How did you hear about the clinic? ............................................................
(if you were referred by an existing patient please print their name as they will be entitled to a clinic voucher)

## About your Complaint

What is the main problem? ............................................................

Please shade area of pain on the diagram below:



On a scale of 0-10 please indicate your usual pain during the past week:

| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Max Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

## Main Complaint

How long have you been aware of the problem **this time**? ..............................

What caused your present symptoms?
☐ Fall ☐ Lifting ☐ Strain ☐ Stress
☐ Road Accident ☐ Industrial Accident
☐ Gardening/DIY ☐ Don't Know Other ..................

Are your symptoms:
☐ Getting better ☐ Getting Worse
☐ Staying the Same ☐ Come & go

What relieves the problem? ..............................
..............................

What aggravates the problem? ..............................
..............................

Does your pain wake you from a sound sleep? ☐ Yes ☐ No
Do you sleep well? ☐ Yes ☐ No ☐ Sometimes
Have you had this problem before? ☐ Yes ☐ No
If yes, what caused it then? ..............................
When do you first remember having this, or a similar pain?
..............................

Have you consulted anyone else about your present symptoms? ☐ Yes ☐ No
If YES, who? ☐ GP ☐ Chiropractor ☐ Osteopath
☐ Physiotherapist ☐ Consultant ☐ Other: ..................
..............................

---

How strongly do you agree or disagree with these two statements:

**"Physical activity makes my pain worse"**

| disagree | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | agree |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

**"I should not do my usual actvities including work with my present pain"**

| disagree | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | agree |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

---

## Previous Health History

Please tick if you suffer from any of the following problems.

☐ Eye problems
☐ Double vision
☐ Dental problems
☐ Jaw pain
☐ Speech problems
☐ Swallowing difficulties
☐ Acid reflux
☐ Ringing ears
☐ Deafness
☐ Skin problems

☐ Chest pain
☐ Productive cough
☐ Difficulty breathing
☐ Wheezing
☐ Fainting
☐ Nausea/vomiting
☐ Loss of appetite
☐ Abdominal pain
☐ PMS
☐ Incontinence

☐ Difficulty urinating
☐ Blood in urine
☐ Bladder or bowel problems
☐ Rectal bleeding/Constipation
☐ Pain in reproductive organs
☐ High BP / heart problems
☐ Headaches
☐ Dizziness
☐ Tremors/inco-ordination
☐ Night sweats

☐ Mood swings
☐ Sleep disturbances
☐ Nervousness/anxiety
☐ Depression
☐ Muscle cramps
☐ Muscle pain
☐ Joint pain
☐ Chronic fatigue / ME
☐ Blood sugar imbalance
☐ Concentration difficulties

---

Please list all serious illnesses (previous & current)
..............................

Have you ever been hospitalised? ☐ Yes ☐ No If yes, why?
..............................

Have you ever had an x-ray? ☐ Yes ☐ No If yes, why?
..............................

Have you ever broken any bones? ☐ Yes ☐ No If yes, when? ..............................

Have you had any of the following tests (please tick):
☐ Urine ☐ Blood ☐ CT Scan ☐ MRI ☐ Bone Scan

Why did you have this test? ..............................
..............................
..............................

When did you last see your GP? ..............................
What was the reason for your visit? ..............................
..............................
..............................

Current Medication? ..............................
..............................
..............................

---

**For Women** When was your last...

Menstrual period ..............................
Cervical smear ..............................
Breast examination ..............................

**For Men** When was your last...

Prostate examination ..............................

---

Have any members of your family (mother, father, grandparents, brothers or sisters) suffered from any of the following conditions?
☐ Diabetes ☐ Heart attack ☐ Stroke/TIA ☐ Arthritis ☐ Cancer ☐ Auto-immune ☐ Thyroid ☐ Epilepsy ☐ Nervous system
☐ Gastro-intestinal (please specify) ..............................
..............................

## Your Lifestyle

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
If so when did you stop? ..................
How many per day? ..................
For how many years? ..................
How many cups of tea/coffee daily? .................. /..................
How much sugar or sweeteners in each? ..................

Alcohol consumption:
☐ None ☐ Daily ☐ Weekly ☐ Occasionally
Units consumed per week: ..................
(Roughly 1 large glass of wine or 1 pint of beer is 3 units)
Are you aware of any food allergies? ☐ Yes ☐ No
If yes please list: ..................
Do you have a special diet? ..................

---

Please tell us your; Height .................. & Weight ..................
Have you lost or gained weight recently? ☐ Yes ☐ No If yes roughly how much? .................. gained/lost (please delete)

What are your hobbies/interests/sports ..................
HOW LONG HAS IT BEEN SINCE YOU HAVE FELT REALLY WELL? ..................

---

## Consent to Examination

I consent to an appropriate physical examination.
Signed .................. Dated ..................

If you are under 16, this consent should be signed by a parent or legal guardian.
Signed.................. (Parent/Guardian) Dated..................

## Consent to Treatment

I have been given a report of findings regarding my condition. I have been advised of, and understand, the possible risks of treatment and have had all my questions answered to my satisfaction. I consent to treatment as outlined to me.
Signed .................. Dated ..................

If you are under 16, this consent should be signed by a parent or legal guardian.
Signed.................. (Parent/Guardian) Dated..................

---

## Consent to storage of patient records

Under the Data Protection Act [1998], we are required to advise our patient(s) on our Data Protection Policy.
As part of your Patient Records, this clinic is required to retain information for the purpose of consultation for the treatment, the recording of subsequent treatments and the contact details, for use by this clinic, its practitioners, receptionists and staff directly involved in the patient management of this clinic.

Upon completion of the patient questionnaire and relevant consent forms, all paper files and information therein maybe electronically stored on computer file for as long as the patient remains a patient at this clinic and thereafter for a period of 7 years.

Any X Rays or other medical images ordered by the chiropractor must be kept by the chiropractor as part of your health record for a period of eight years after the date of your last visit. This is one of the legal requirements of the Code of Practice published by the General Chiropractic Council (GCC) – the UK wide statutory regulator of chiropractors. Should you want another health professional to look at your X Rays or other medical images, your chiropractor may be willing to release them to you or, with your consent, to your health professional of choice. Although this must be on the clear understanding that the X Ray films or other medical images will be returned to your chiropractor. A letter of release needs to be completed before this can be undertaken.

All information provided will be treated as confidential and will not be given to any other person(s) organization(s) without the written consent of the patient concerned.

I, the undersigned, do hereby give consent to the Shoreham Chiropractic Clinic, its practitioners, receptionists and staff to maintain records as required for the duration of my treatment as outlined above.
If you are under 16 years of age, this consent should be signed by a parent or legal guardian.

Signed .................. Patient/Guardian/Parent Dated ..................