CHIROPRACTIC & COMPLEMENTARY MEDICAL CENTRE

CONFIDENTIAL PATIENT RECORDS

Any personal information we collect from you will be handled under the General Data Protection Regulation (2018), and we will not pass on your personal information to any third party without your consent.

1. PERSONAL DETAILS

Surname: _____ Mr, Mrs, Miss, Ms Other:_____

Forename(s):_____ Date of Birth: _____/_____/_____

Full Address: _____ Post Code: _____

Marital Status: _____ Number and Age of Children:_____; _____

Tel No. Mobile: _____Home:_____

E-mail address:_____

How did you hear about us (if referred please provide a name)?_____

Do you intend to reclaim your fees through health insurance? Yes/No which company?_____

2. EMPLOYMENT DETAILS

Occupations (current/previous):_____How long(years)_____

What does your job involve (e.g. sitting, lifting)?_____

3. HEALTH DETAILS

Name of GP: _____ Practice Address:_____

Current Medication:_____

Have you consulted your GP about any Medical Conditions recently? Yes/No

Details:_____

Have you had any:

- Significant illness? If yes, give details:_____
- Road Traffic or other Accidents (date):_____
- Broken bone (date):_____
- X-rays/MRI/CT taken (date): _____
- Previous Operations/Hospitalisation(date):_____

Do you smoke? Yes/No. Did you used to smoke? Yes/No. If yes _____per day and how long(years)_____

How many units/cups do you drink per week of: Alcohol(units)?_____Tea/Coffee(cups)?_____

Do you do regular exercise? YES/NO Details:_____

4. PRESENT COMPLAINT(S)

Where is/are the pain/symptom(s)?_____

_____

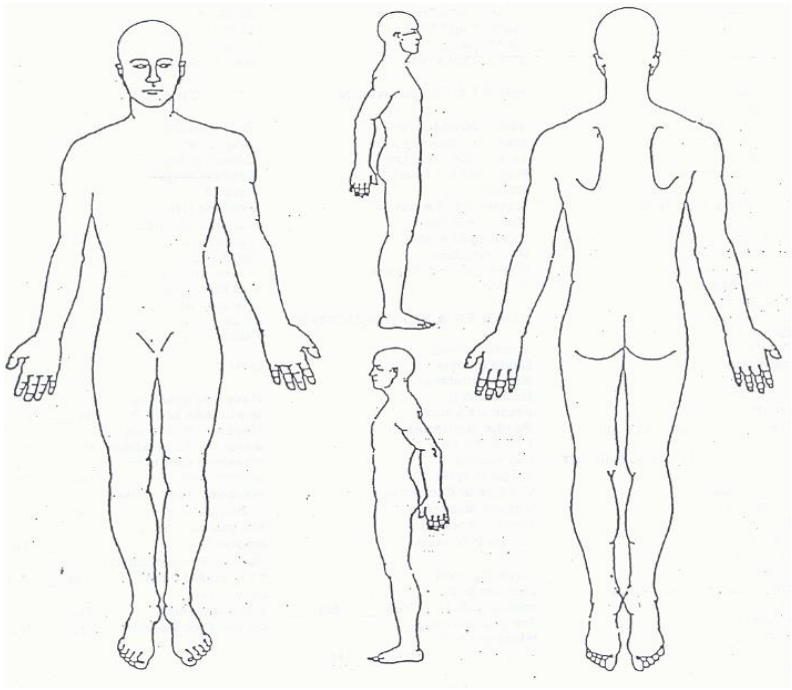
How long have you had the pain/symptom(s)?_____

Do you have any other complaints?_____

_____

Please indicate the location and type of symptoms you have on the diagram below:

Sharp pain	**=**	**S**
Dull pain	**=**	**D**
Stiffness	**=**	**ST**
Tingling	**=**	**T**
Numbness	**=**	**N**
Burning	**=**	**B**
Bone Pain	**=**	**BP**
Cramping	**=**	**C**



Please circle the minimum and maximum intensity of the symptoms over the last week on the scale below:

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

5. HAVE YOU OR YOUR IMMEDIATE FAMILY SUFFERED FROM ANY OF THE FOLLOWING?

Condition	Self	Immediate family (who?)
Heart Problems / Blood Pressure		
Stroke		
Cancer		
Diabetes		
Arthritis		
Allergies / Skin problems		
Breathing problems		
Bowel / Bladder problems		
Migraines / Headaches		
Dizziness / Balance problems		
Eyes/Ears/Nose/Throat problems		
Neurological disorders (e.g.MS)		
Weakness, Fatigue or Tiredness		
Others		

CONSENTS

- ✓ I agree in principle to an appropriate examination and treatments.
- ✓ I give my consent for the clinic to maintain my records for the purpose outlined in the Privacy notice.
- ✓ I'm happy to be contacted by email or post regarding appointments and other clinic information.

Patient / Guardian's Signature: _____**Date** _____ /_____ /_____

(If a patient is under 16, this consent should be signed by a parent or legal guardian.)