Manchester Chiropractors

PATIENT FORM

Member No:
Consultation Date:
DC:
Oxygen Stats:

Please indicate your main reason for visiting us: (ie. injury, back pain, sciatica etc.)

_____

How long have you had this pain? _____

Type Of Pain
- ○ Ache
- ○ Burning
- ○ Dull
- ○ Numbness
- ○ Pins and needles
- ○ Sharp
- ○ Stabbing
- ○ Weakness

How Did It Start?
- ○ Accident
- ○ Bending/twisting
- ○ Gradually
- ○ Lifting
- ○ Not sure
- ○ Sports
- ○ Suddenly
- ○ Woke with it

What Makes It Worse?
- ○ Bending/Lifting
- ○ Cold/damp weather
- ○ Driving
- ○ End of the day
- ○ Heat
- ○ Rest
- ○ Mornings
- ○ Rising from seated
- ○ Prolonged sitting/standing
- ○ Walking

Is It?
- ○ Constant
- ○ Intermittent
- ○ Up and down
- ○ Good/bad days
- ○ Getting worse
- ○ Getting better
- ○ Staying the same

What Makes It Better?
- ○ Heat (wheat bag or bath)
- ○ Ice
- ○ Keeping busy/movement
- ○ Massage
- ○ Painkillers

Rate your pain on a scale of 0-10
(0-no pain, 10-worst pain possible).

If you are suffering from something not listed above please indicate here _____

Have you previously been treated for this condition or something similar? ○ Yes ○ No Please give details: _____

In what ways does this condition affect your lifestyle?

- ○ Hinders sports/hobbies
- ○ Interferes with job
- ○ Restricts daily activities
- ○ Restricts household duties
- ○ Worry about future health
- ○ Hinders sleep
- ○ Moody/Irritable
- ○ Exhausted
- ○ Distracted by symptoms / Give details: _____
- ○ Other _____

Please help us to get a picture of your general health by answering the following questions:

Please complete where applicable

Do you currently smoke? ○ Yes ○ No Have you ever smoked? ○ Yes ○ No When did you stop? _____

Do you drink alcohol? ○ Yes ○ No How many units per week? ○ 0-10 ○ 11-21 ○ 22+

Do you have children? ○ Yes ○ No Ages _____

Are you pregnant? ○ Yes ○ No When was your last period? _____

Have you visited your GP recently, if so, give date if possible and briefly why you made this visit _____

In the recent past (6 months) have you experienced any of the following: ○ Weight loss ○ Fatigue ○ Unrelenting pain at night ○ Night Sweats

Please give us brief details _____

Are you currently suffering from, or have you in the past suffered from:

- ○ Cold sweats
- ○ Constipation
- ○ Cystitis
- ○ Diabetes
- ○ Diarrhoea
- ○ Difficulty breathing
- ○ Difficulty urinating
- ○ Dizziness
- ○ Eating disorder
- ○ Eczema / skin problems
- ○ Allergies
- ○ Angina
- ○ Ankle swelling
- ○ Anxiety/stress disorder
- ○ Arthritis
- ○ Asthma
- ○ Bladder infections
- ○ Bloating/gas
- ○ Cancer
- ○ Chest pains
- ○ Jaw pain/clicking
- ○ Joint swelling
- ○ Loss of balance
- ○ Loss of consciousness
- ○ Loss of taste/smell
- ○ Loss of vision
- ○ Low blood pressure
- ○ Numbness
- ○ Orthodontic work
- ○ Palpitations
- ○ Period pains
- ○ Pins & needles
- ○ PMT
- ○ Prostate problems
- ○ Rapid weight loss
- ○ Sinus problems
- ○ Stroke/TIA
- ○ Teeth removed
- ○ Varicose veins
- ○ Visual disturbances
- ○ Epilepsy/seizures
- ○ Eye problems
- ○ Fatigue/tiredness
- ○ Grinding teeth
- ○ Headaches
- ○ Heart attack (s)
- ○ Hearing problems
- ○ High blood pressure
- ○ Indigestion / acid reflux
- ○ Irregular periods

In the past have you had X-Rays or MRI scans? ◯ Yes ◯ No Please indicate details of investigation and approximate dates:

Are you currently under a specialist's care or attending hospital? ◯ Yes ◯ No Please explain briefly: _____

Do you take any vitamin or other dietary supplements? ◯ Yes ◯ No If yes please list: _____

Are you currently taking medication prescribed by your doctor? ◯ Yes ◯ No If yes please list below:

Drug name:	Reason for taking:	Date started:

Have you ever had surgery? ◯ Yes ◯ No If yes please list below:

Surgical procedure:	Date of surgery:

Have you ever been in an accident? RTA, sport, work related ◯ Yes ◯ No If yes please list below:

Type of accident:	Date of accident:	Injuries (broken bones/unconsciousness etc):

Please indicate if anyone in your blood family has suffered from Cancer, Hepatitis, Diabetes, Tuberculosis, Epilepsy, Rheumatoid Arthritis or Stroke?

◯ Yes ◯ No Please give details: _____

Personal Details:

Title: _____ First Name: _____ Surname: _____

Sex: _____ Date Of Birth: _____ Age: _____

Occupation: _____ Height: _____ Weight: _____

Address: _____

_____ Postcode: _____

Tel: _____

Email Address: _____

GP's Name & Address: _____ Postcode: _____

Please sign in the understanding that you have given all information fully, in order to help the chiropractor with their diagnosis and to permit the chiropractor to examine and treat you according to the findings.

I, _____ (please print name) understand that the chiropractor needs to make a professional examination of my condition in order to make a diagnosis, I hereby give full consent to this examination and the following treatment if required.

◯ I agree to my medical notes being released should I need to be referred elsewhere.

Signed: _____ Patient/Parent/Guardian (Please delete as not applicable) Date: _____

Thank you for completing the form. Please return the form to the front desk.

Data protection disclaimer All information provided will be kept in the strictest confidence and in accordance with the Data Protection Act.
We will not share information with any third party without your consent.

How did you hear about us?

Google ◯ Social Media ◯ Walk by ◯ Recommended ◯ Who should we thank for your referral? _____