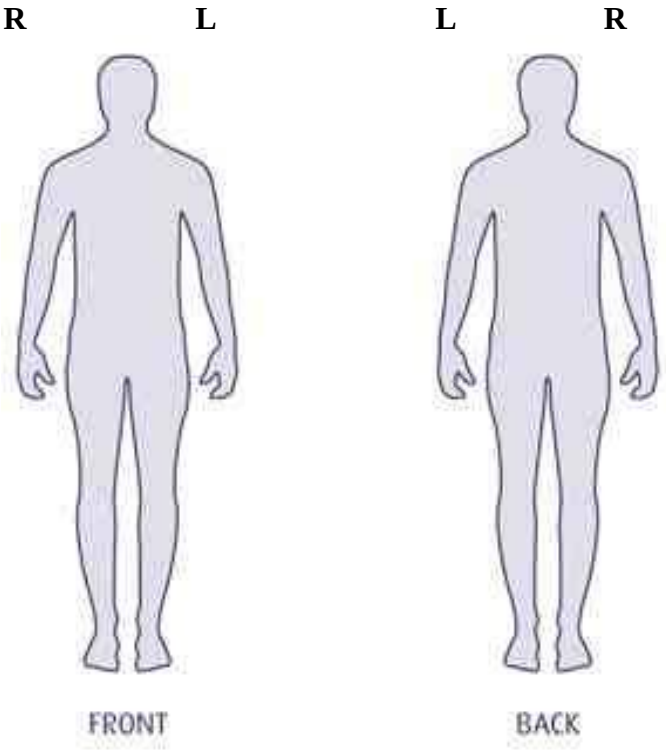
SURNAME: **FIRST NAME:** **MALE/FEMALE**	**GP's NAME:** **ADDRESS:**
HOME ADDRESS: **POSTCODE:**	**CURRENT OCCUPATION:** **NUMBER OF YEARS IN CURRENT POSITION:**
DATE OF BIRTH: **AGE OF FIRST VISIT:** **AGES OF CHILDREN:**	**TEL NO. (DAY):** **TEL NO. (EVENING):** **MOBILE:** **EMAIL:**
WHAT DO YOU WANT FROM YOUR VISIT? □ **PAIN RELIEF** □ **IMPROVED MOVEMENT** □ **CHECK-UP** □ **OTHER**	**HOW DID YOU HEAR ABOUT OUR CLINIC?**

Mark the areas on your body where you feel the described sensations.

Use the appropriate symbol.

Pain/Ache /////
Stiffness ○○○○
Weakness ====
Numbness xxxx



If you have pain…
On average how intense has your pain been over the past week?

No pain 1 2 3 4 5 6 7 8 9 10 Worst ever

NAME: _____ **DATE:** _____.

DO YOU/HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?	NO	YES	DETAILS – INCLUDE FAMILY HISTORY
Dizzy spells /Unsteadiness/ Blackouts			
Stroke			
Migraine or Non-Migraine Headaches			
Epilepsy			
Buzzing in the ears (Tinnitus)			
Blurred vision/Double vision/Eye problems			
Depression/Schizophrenia			
Pain/Odd sensation in the limbs			
Breathing/Lung problems			
Heart/Blood pressure problems			
Digestion/Bowel problems			
Kidney/Bladder problems			
Liver problems/Jaundice			
Reproductive/Menstrual/ Prostate problems			
Hormonal problems			
Diabetes			
Arthritis			
Weak/Brittle bones/ Osteoporosis			
Ear/nose/throat problems			
Skin problems			
Cancer			

Are you being treated for any other condition? **Are you pregnant/think you may be pregnant?** **Are you vegetarian/vegan?** **Do you smoke? How many per day……..?** **Do you drink alcohol? Units per week……..?** **Do you exercise regularly?** **Have you lost weight recently?** **Have you had surgery?** **Have you had any major falls/accidents?** **Is your problem something that has happened gradually?**	**Is your problem something that hurts all the time?** **Is your problem something that runs in the family?** **Please list any medication you are taking:** **Please list any investigations you have had:**

NAME: _____

PATIENT CONSENT AND DATE PROTECTION

Please read the following carefully before signing. Ask your chiropractor to explain any points that are not clear to you.

I have had my chiropractic treatment explained to me and give my consent to the following:

1. To be examined and treated by Uxbridge Chiropractic Clinic staff knowing that adverse reactions or complications can not be excluded(1).

2. For my GP to be contacted about my chiropractic treatment.

3. For information about me to be used for research, audit or disclosed to third parties such as health professionals in accordance with Data Protection Act 1988 and the Chiropractors Act 1994, including those statutory instruments made thereunder.

4. To be responsible for meeting the cost of my treatment up to the full amount should my insurer or nominated third party decline to do so.

***Signed _____ Date _____.**

* If the patient is under 16 years of age, this consent should be completed by the patient's parent of guardian.

1. The most commonly reported reactions to chiropractic treatment are local discomfort, headache, tiredness and radiating discomfort. Very rare complications include cauda equine syndrome, stroke. Stenstad, O., Leboeuf-Y de C. Borchgrevink, D. (1997). Spine 22:435-441.

PRIVATE HEALTH INSURANCE

Are you covered by private health insurance? If so which one? _____.