MERN CHIROPRACTIC

	MR/MS/MRS/DR/PROF
	FIRST NAME(S)
	SURNAME
ADDRESS	POSTCODE
D.O.B. / AGE	MARRIED/SINGLE/PARTNERED/WIDOWED
OCCUPATION	EMAIL
PHONE	MOBILE
G.P. NAME / SURGERY ADDRESS	

MEDICAL HISTORY

How would you describe your general health?				Excellent 1 – 2 – 3 – 4 – 5 Very Bad
Your Height:				Your weight:
Do you smoke?	Y/N	Do you drink?	Y/N	If **Yes**, how many units a week?

Which exercises/sports do you do?	
How often do you exercise?	
Do you have any known allergies?	Y / N
If **Yes** please give details:	
Have you ever had a serious illness?	Y / N
Have you ever had any breathing problems?	Y / N
Have you ever had any urinary complaints?	Y / N
Do you suffer from headaches or migraines?	Y / N
Have you seen your G.P. in the last 6 months?	Y / N
Are you taking any medication, including supplementation? (the chiropractor will discuss this further)	Y / N
Have you had any operations, including major dental work?	Y / N
If **Yes** please give dates:	
Have any of your family members suffered any serious illnesses? (i.e. cancer; stroke; heart attack; diabetes; neurological problems; arthritis etc.)	Y / N
[Females only] Are you pregnant, 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 w/pain the next day
How long have you had this problem?					
Have you ever had anything similar before? (If so, give details)					
Do your symptoms radiate into the arms/legs, fingers/toes?					

Please describe your pain:

Dull – Sharp – Aching – Stiffness – Shooting – Burning – Tingling – Numbness

or Other (describe):

Are your symptoms:

Constant – Come & Go – Weekly – Monthly - Improving - Worsening – Same since onset

or 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?	

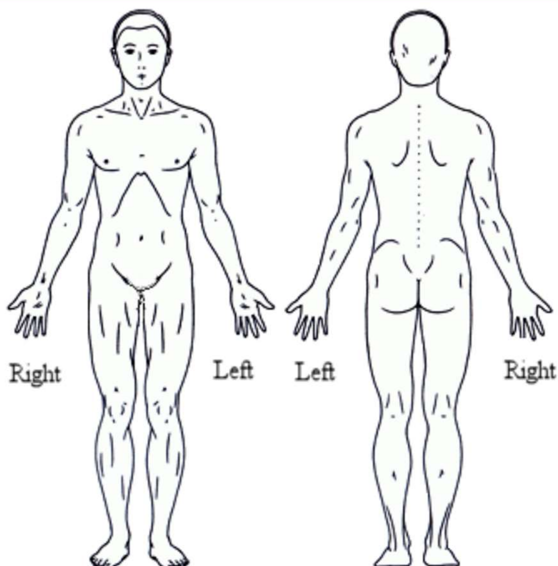
What makes the symptoms better?

Meds – Heat – Cold – Movement – Rest

or Other (describe):

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 this diagram the location and character of your pain/discomfort:

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

PRESENTING COMPLAINT (continued)		
Does your GP know about this condition?		Y / N
What other treatments have you received for this problem? (give details of where and when)		
Did the above help?		Y / N / NOT SURE
How many treatments did you have?		
Were any investigations carried out?		Y / N
If Yes was it:	X-Ray / MRI / CT / Bone Scan / Blood Tests / Other:	
Where and when:		
What were the results?		
Is your condition work-related?		Y / N / MAYBE
Have you had any accidents or injuries that may have caused or contributed to your problem?		Y / N
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?	Y / N
If **Yes**, please give name of provider:	

EXAMINATION CONSENT

I consent to an appropriate examination

Signed: ....

Date:...

TREATMENT CONSENT

(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 Dr. Laura Nuttall.
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 (Patient) .... Date: ....

Signed (Chiropractor) .... Date: ....

DATA PROTECTION

Under the GDPR (2018) regulations we are required to advise you of our Data Protection Policy which is available in full by request or on our website. We process your data in lawful and transparent manner. We only gather information that we need, it will always be available to you free of charge and it is securely stored. As part of the patient record, this clinic is required to retain information for the purpose of consultation, for treatment, recording subsequent treatments and for the use by third party medical practitioners only at the request of the patient in writing. Upon completion of this form all paper files and electronic records will be kept for as long as the patient remains a patient of the clinic and thereafter for a period of 7 years. All information is confidential and will not be given to any person or organisation without the written consent of the patient concerned. All data is held either electronically or on paper in files accessible only by clinic staff who are directly involved in the data entry and processing of patient records.