NAME:	DATE OF BIRTH:	AGE:
ADDRESS:		
CONTACT DETAILS MOBILE:	HOME:	
E-MAIL ADDRESS:	OCCUPATION: CHILDREN:	
WHERE DID YOU HEAR ABOUT THE CLINIC:	GP NAME & CONTACT NO.:	

DESCRIBE YOUR CURRENT PROBLEM AND WHEN IT BEGAN:

____

HOW DID YOUR POBLEM BEGIN?

Quality:

Dull / Sharp	Stiffness	Stabbing
Numbness	Throbbing	Pulling Sensation
Tingling	Burning	Aching

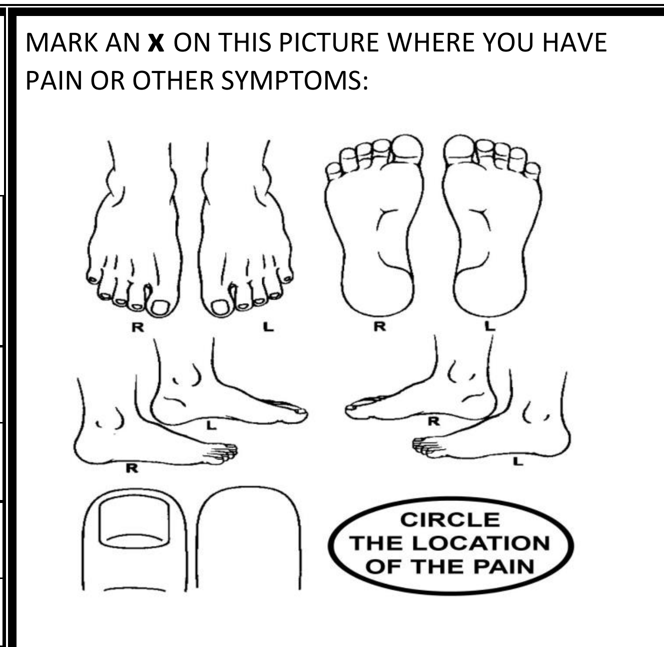
Severity / Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

What makes it worse:

What makes it better:

SHOE SIZE: ________________ **WEIGHT:**_____________________

MARK AN **X** ON THIS PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:



How often are your symptoms present? (Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)?

0 1 2 3 4 5 6 7 8 9 10

No interference — Unable to carry on any activities

In general how would you say your overall health is right now:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint? ☐ No ☐ Yes

Date(s) taken ______________________________ What areas were taken? ________________________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date _______________________)
☐ Corticosteroid Use (Cortisone, Prednisone etc.)
☐ Taking Birth Control Pills
☐ Dizziness / Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain ____________________________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain ____________________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently pregnant, # weeks _______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries ______________________________________
☐ Tobacco use – Type:___________________________
Frequency:______ _____day
☐ Medications

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

CONSENT

I consent to a physical examination by my Chiropractor, to included (as needed) foot examination and Gaitscan.

Signed: ______________________________
Date: ______________________________
PATIENT or PARENT/ GUARDIAN (if under 18 consent must be given by parent or legal guardian.)

I confirm that I have received a full explanation, of the outcomes of the Chiropractor's assessment and a diagnosis/rationale for care and proposed treatment plan; in terms that I can understand.

I have had the opportunity to ask questions in respect of my reason for attending a Chiropractor. I understand that it is my right to seek a second opinion, at any time; should I wish.

I have been advised of the care options, both Chiropractic and alternates, available to me and acknowledge that any decision to proceed, is based on a full understanding; of the likely benefits and any reasonably foreseeable risks of care. I understand that the outcomes of care, cannot be guaranteed.

I confirm that the financial implications of the proposed plan of care and any available options have been explained to me.

I hereby give consent to the Chiropractor, to retain my personal information, (under GDPR Guidelines); for the purpose of my healthcare.

I also confirm that, I am content, when the Chiropractor deems it necessary and appropriate, I consent for my Chiropractor to contact my general medical practitioner (GP) and for the Chiropractor, using any appropriate means; to discuss aspects of my health or care with my GP.

I understand that the chiropractic diagnosis and treatment plan proposed, is based on the information that I have given to the Chiropractor.

I understand that it is my right to decline care, or withdraw from care, or any aspects of care, at any time. I also understand that I am free to withdraw my consent, to aspects of care.

I understand that I must be committed to attend sessions, on a consistent basis to receive the greatest benefit from treatment. Although I may stop treatment at any time, I agree to inform the Chiropractor of my decision, so that you are aware of my intentions in good time, before the next appointment.

Based on the above, I freely and voluntarily consent to receiving chiropractic care.

Signed: ____

Print Name: ____

Date: ____

PATIENT or PARENT/ GUARDIAN (if under 18 consent must be given by parent or legal guardian.)