WELLSPRING CHIROPRACTIC CLINICS – Glanmire –

Tel: 021-4824450
Fax: 021-4820766
Eastcliffe House, Glanmire, Cork
E-mail: info@wellspringchiropractic.ie

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date of Birth:**
Address:	
Mobile phone:	**Home/Work phone:**
Occupation:	**G.P.:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**

E-mail address: _____

Who may we thank for referring you?

_____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Which activities aggravate your condition?

_____

_____

What Other doctors you have seen for this condition:

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays/scans taken?

Area of body:	When?	Where?
Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

CONSENT

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

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

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.

Based on the above, I freely and voluntarily give my consent

Signed: _____

Print Name: _____

Date: _____

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