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

Pursuant to the Data Protection Acts 1998 and 2003, we are required to advise patients of our Data Protection Policy.

POLICY

In line with GDPR guidelines as part of a patient's records this Clinic retains information for the purposes of consultation for treatment, recording treatments and payments and use by third party medical practitioners and third party payers such as health insurance companies.
All paper files and information contained within a patient's records may be electronically scanned and stored on a computer file for as long as the relevant patient remains a patient of this Clinic, and for a period of at least 7 years thereafter. Paper records will be retained for the same period.
All information held both in paper and electronic formats will be accessible only by the staff of this Clinic who are directly involved in the data entry and processing of patient records. Other than for the purposes stated here, information will not be released except with the patient's written consent, or as required by law.

- I hereby acknowledge that I have read the above Data Protection Policy and hereby give consent to the maintenance of my records for the purposes outlined within said Policy.
- I consent to physical examination by my Chiropractor, to include (as needed) foot examination and Gaitscan.
- I hereby authorise you to contact my Healthcare Provider, GP and/or Medical Imaging company to obtain reports e.g. MRI reports, X-ray reports etc and/or information pertaining to myself and to write to them following my treatment.

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 a parent or legal guardian.)