

New Patient Health Questionnaire

Welcome to Spinewaves. Our aim is to deliver a first class service tailored to your needs. The files held at this clinic are **STRICTLY CONFIDENTIAL**. Please complete the form in ink. The information you provide here will help us in preparing your file. For us to decide whether your problem is suitable for chiropractic, we are required to assess all aspects of your current state of health. If you require assistance please ask, we are happy to help.



Mr/Mrs/Miss/Ms/Mx/Master/Dr Forename(s) _____ Preferred name _____
Surname _____ E-mail address: _____

Please tick if you would like to receive our recommended educational newsletters/health updates

Address _____ Home phone _____
_____ Mobile phone _____
County _____ Date of Birth ____/____/____ Age _____
Postcode _____ Occupation _____

Are you: Male Female M->F F->M **Gender:** Man Woman Agender NonBinary Trans GenderFluid

Status: Married Single With partner Divorced Widowed Separated

Do you have any children? Yes No If so, how many? _____

Who referred you to this clinic? GP Passing by Advertisement >Where? _____

Internet Where? _____ Family Friend >Who? _____

Do you have private health insurance? Yes No If YES, what is the name of your fund? _____

Your GP's name _____ Where do they practice? _____

May we contact or write to your GP if we feel it is necessary for your case? Yes No

MAJOR COMPLAINT

Describe your major complaint(s) or symptom(s): _____

How long have you been aware of the problem this time? _____

What caused your present symptoms? Fall Lifting Strain Stress Road accident
Work accident Gardening/DIY Don't know

What RELIEVES the pain/problem? _____ --

What AGGRAVATES the pain/problem? _____

Are your symptoms: Getting better Getting worse Staying the same Seem to come & go

Have you had this problem before Yes No If yes, what caused it then? _____

If so, when do you first remember having this, or a similar problem? _____

What treatment did you have? _____ Did it help? Yes No

Have you consulted anyone else about your present symptoms? Yes No

If YES, who? GP Chiropractor Osteopath Physiotherapist Consultant Other: _____

Are you seeing the doctor for any other reason? Yes No Details? _____

Have you noticed any blood in your stools, urine or when coughing? Yes No

Have you had any loss of bowel or bladder control? Yes No

Have you lost consciousness or had double vision recently? Yes No

YOUR LIFESTYLE

Do you smoke? Yes No Have you ever smoked? Yes No If so, when did you stop? _____

How many per day? _____ For how many years? _____ How much tea/coffee daily? _____/_____

Quantity of sugar/sweeteners in each? _____ Quantity of alcohol? None Daily Weekly Occasionally

Does your pain wake you from a sound sleep? Yes No Do you sleep well? Yes No Sometimes **PTO**

Are you aware of any food allergies or cravings? Yes No If so, please list: _____

Are you on a salt or sugar free diet? Yes No Is your Diet Mixed or Vegetarian

Has your weight changed considerably in the last 3 months? Yes No

PREVIOUS HEALTH HISTORY

Have you ever had any operations? Yes No If YES, please complete below:

Year _____ Operation _____ Year _____ Operation _____

Year _____ Operation _____ Year _____ Operation _____

Please list all major past illnesses, diseases or conditions you have had:

Year _____ Condition _____ Year _____ Condition _____

Year _____ Condition _____ Year _____ Condition _____

Have you ever been in any car accidents? Yes No If YES, please complete below:

Year _____ Injuries _____ Year _____ Injuries _____

Have you had any other accidents, falls or injuries? Yes No If YES, please complete below:

Year _____ Injuries _____ Year _____ Injuries _____

Have you ever fractured any bones? Yes No If YES, please complete below:

Year _____ Bone _____ Year _____ Bone _____

Please list any medication/tablets or drugs you are currently taking:

Name _____ What for? _____ Name _____ What for? _____

Name _____ What for? _____ Name _____ What for? _____

Please list any vitamins/ minerals/herbs etc.: _____

Please list all x-rays you have had in the last 5 years:

Year _____ Part x-rayed _____ Year _____ Part x-rayed _____

As some health problems are as a result of hereditary factors, please list any conditions that your family has:

Father _____ Mother _____

Brother/Sister _____ Grandparents _____

If you are female, is there any possibility that you might be pregnant? Yes No

How long has it been since you have felt really well? _____

Data Protection Policy

Under the General Data Protection Rules (2018), as a health service provider, we are required to advise our patient(s) on our Data Protection Policy for the purpose of consultation, examination and treatment. As part of the Patient Record, the Clinic is required to retain information for the purpose of consultation for treatment, recording subsequent treatments, and for use by third party medical practitioners only, at the request of the patient, in writing. Information will be held both manually and electronically in files accessible only by staff of the Clinic who are directly involved in the data entry and processing of patient records. Information will be kept for as long as the patient remains a patient of the Clinic, and thereafter for a period of 8 years (or age 25 if longer), after which the patient has the right for their data to be erased, providing there is no overriding legal reason. All information provided will be treated as confidential, and will not be given to any other person(s)/organizations(s) without the explicit consent of the patient concerned. With the exception of Employees, Partners and Owners of the practice. Our full Privacy Policy is available in the clinic patient information folder and can be found on our website: www.spinewaves.co.uk/info/privacy

I consent to being examined after the consultation: Signature: _____ Date: / / .

Informed Consent to Treatment - To be completed after Examination and Review of Findings

- I have received a full explanation of my condition including Differential diagnosis
- I have had the opportunity to ask questions
- I have been advised of care options and the likely benefits.
- I understand that reassessments and reviews may be performed as and when required
- I have been advised of possible side effects and risks associated with treatment

I the undersigned (or authorised Guardian)**, understand my condition and the proposed care plan as it has been explained to me. I agree to the procedure(s) and/or course of chiropractic care as described. I confirm I have been made aware of the clinic data policy.

Patient Signature _____ Name (PRINT) _____ Date / /

** Patients under the age of 16: a parent or guardian is ideally required to sign (persons under the age of 16 may still consent).