

Welcome to Spinewaves. Our aim is to deliver a first class service tailored to your needs.

All of the information you provide remains confidential to this practice.

Personal Information

Title _____ Surname: _____ Female Male

First Name(s) _____ Known as: _____

Address: _____

Post Code _____

Day Time Tel: _____ Evening Tel: _____ Mobile: _____

E-Mail: _____

Please tick if you DO want newsletters/health tips/advice

Date of Birth: _____ Do you have children? Y/N _____ If so, what age(s)? _____

Who may we thank for referring you to us? _____

Occupation: _____

Describe your daily activities (driving, lifting, outside) : _____

Emergency Contact Number: _____

Name: _____ Relationship _____

GP Details:

Doctor's Name: _____ Practice : _____

Address: _____

May we contact your GP to update them on your health status? Yes No

Your Health Profile:

Why This Form Is Important

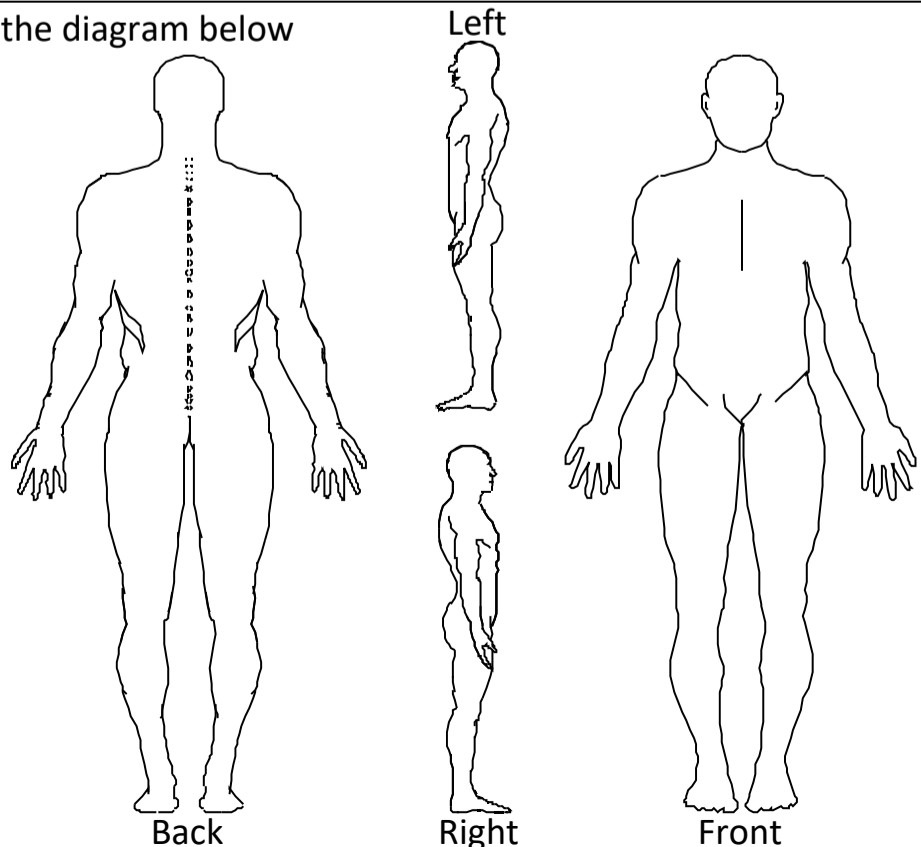
To help us identify the right approach for you we need to understand the reasons that lead you to us and what you want to achieve from your treatment in the short and long term. Therefore we ask you to spend a short time completing the form below in order to help us build an accurate picture of you and the issues you want us to address. Please answer the questions as completely and honestly as you can.

Please briefly describe your chief concern, including the effect it has had on your life.

Your Health Concerns

Please indicate any areas of issue on the diagram below

KEY	
/////	Stabbing
XXXX	Burning
OOOO	Pins & Needles
-----	Numbness
++++	Aching



Health Concerns:	Concern 1	Concern 2	Concern 3
<i>List health concerns according to their severity</i>			
Rate of Severity 1= mild 10= worst imaginable			
When did this episode start?			
How did this problem start?			
Are the symptoms.....			
Constant or Intermittent?			
Sharp or Dull?			
Does the pain travel?			
Getting better or worse?			
Worse morning or evening?			
Worse sitting, standing, bending, walking, lying?			
Have you done anything that helps?			
If you had the condition before, when?			
What treatment have you had, does it help?			
Please tell us how it affects you:			
Does it make you	<input type="checkbox"/> Moody <input type="checkbox"/> Irritable <input type="checkbox"/> Interrupt sleep <input type="checkbox"/> Exhausted at the end of the day	<input type="checkbox"/> Moody <input type="checkbox"/> Irritable <input type="checkbox"/> Interrupt sleep <input type="checkbox"/> Exhausted at the end of the day	<input type="checkbox"/> Moody <input type="checkbox"/> Irritable <input type="checkbox"/> Interrupt sleep <input type="checkbox"/> Exhausted at the end of the day
Does it affect Work?	<input type="checkbox"/> Decision making <input type="checkbox"/> Negative attitude <input type="checkbox"/> Reduced Productivity <input type="checkbox"/> Restrict Mobility	<input type="checkbox"/> Decision making <input type="checkbox"/> Negative attitude <input type="checkbox"/> Reduced Productivity <input type="checkbox"/> Restrict Mobility	<input type="checkbox"/> Decision making <input type="checkbox"/> Negative attitude <input type="checkbox"/> Reduced Productivity <input type="checkbox"/> Restrict Mobility
Does it affect Home Life?	<input type="checkbox"/> Lose your patience easily <input type="checkbox"/> Restrict daily activities <input type="checkbox"/> Stop or restrict exercise or sport <input type="checkbox"/> Interfere with hobbies or activities	<input type="checkbox"/> Lose your patience easily <input type="checkbox"/> Restrict daily activities <input type="checkbox"/> Stop or restrict exercise or sport <input type="checkbox"/> Interfere with hobbies or activities	<input type="checkbox"/> Lose your patience easily <input type="checkbox"/> Restrict daily activities <input type="checkbox"/> Stop or restrict exercise or sport <input type="checkbox"/> Interfere with hobbies or activities
What else is this affecting?	<input type="checkbox"/> Partner <input type="checkbox"/> Children <input type="checkbox"/> Work <input type="checkbox"/> Hobbies <input type="checkbox"/> Self esteem <input type="checkbox"/> Finances	<input type="checkbox"/> Partner <input type="checkbox"/> Children <input type="checkbox"/> Work <input type="checkbox"/> Hobbies <input type="checkbox"/> Self esteem <input type="checkbox"/> Finances	<input type="checkbox"/> Partner <input type="checkbox"/> Children <input type="checkbox"/> Work <input type="checkbox"/> Hobbies <input type="checkbox"/> Self esteem <input type="checkbox"/> Finances
Helping this issue would improve my quality of life by:	<input type="checkbox"/> 0-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 0.9 <input type="checkbox"/> 1	<input type="checkbox"/> 0-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 0.9 <input type="checkbox"/> 1	<input type="checkbox"/> 0-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 0.9 <input type="checkbox"/> 1
Tell us what worries you the most about this problem			
Any other comments			

General History Please tick all symptoms you have or had in the past, even if it does not seem related to your current problem			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Angina	<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest pains
<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Chronic Thrush	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cystitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Difficulty urinating
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eczema/skin problems	<input type="checkbox"/> Epilepsy/fits	<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Fatigue/Tiredness	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart attack(s)
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Jaw pain/Clicking
<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Loss of taste/smell
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Numbness	<input type="checkbox"/> Orthodontic work
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Rapid weight loss
<input type="checkbox"/> Stroke/T.I.A.	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Teeth removed	<input type="checkbox"/> Varicose veins
Please tell us of any other issues :			

Medical history

Please list all **MEDICATION** that you are taking:

Drug Name	Reason for taking	Date started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **SUPPLEMENTS** that you are taking:

Supplement Name	Reason for taking	Date started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **ACCIDENTS** or **INJURIES** you have had: (Including broken bones)

Please list all **INVESTIGATIONS** you have had: (Including MRI and X-Ray)

Please list all **Surgery or Hospitalisation** you have had:

Are you currently under a Doctor or Consultant for any issues?

No Yes Details:

Family History

Has anyone in your immediate family ever suffered from: Cancer, Hepatitis, Diabetes, Epilepsy, Tuberculosis, Rheumatoid Arthritis or Stroke?

No Yes Details:

Do you take part in any regular exercise?

No Yes How often and what type:

Do you smoke:

No Yes How many per day

Do you want to cut down/give up

Do you drink Alcohol:

No Yes How many per units per week

Do you want to cut down/give up

Female specific Questions

Are you pregnant? No Yes

Do you have irregular periods? No Yes

Do you have painful periods? No Yes

Do you suffer from PMT No Yes

Are you on HRT? No Yes

How many children have you given birth to?

Did you experience complications No Yes

Have you had a caesarian section No Yes

Have you had a Hysterectomy? No Yes

Your Spine

Do you have a spinal curvature, spinal arthritis or inherited spinal problems? No Yes

Do you ever hear cracking or grinding noises when you move your neck or head? No Yes

Do you ever feel the need to twist, stretch or crack your neck or back? No Yes

Please rate your posture on a scale of 0 to 10 (1 = very poor, 10 = excellent)

Postural problems can run in families does anyone in your family have similar problems No Yes

Your Health Goals. (Help us to understand your expectations and what is important to you.)

Are you happy with the way you look and feel? Happy 1 2 3 4 5 6 7 8 9 10 Unhappy

How long has it been since you have felt your best? Years Months Days

How long have you been thinking about pursuing your health goals? Years Months Days

What are you most interested in improving?

Less Pain/Symptoms Reducing Stress Increasing Energy & Vitality Overall Health

How long do you think it will take to achieve your health goals? Years Months Days

Where do you picture yourself being in 1-2 years if problem isn't taken care of? Be specific

What would be different / better without this problem? Be specific

What do you want achieve most from working with us?

Thank you for answering our questions

I consent to being examined after the consultation: Signature:

Date: / / .

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)s, 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

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 will be performed at 6-12 visit intervals

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 understand that if NSA (Network) care is given it can be in an open room setting. If I prefer/or require a closed room, ie to discuss any problems, I will inform reception when I attend. I confirm I have been made aware of and understand the clinic data policy.

2. 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).