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 educational and informative 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**

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 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).