New Patient Health Questionnaire

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. Please complete the form in ink. The information you provide here will help us in understanding your condition and 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 help at any stage please ask, we are happy to help. The files held at this clinic are STRICTLY CONFIDENTIAL.

Mr/Mrs/Dr/Master/Miss/Ms Forename(s)_____ Preferred name_____

Surname_____ E-mail address: _____

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

Address _____ Home phone_____

_____ Mobile phone_____

_____ Best No. for Emergency _____

County _____ Date of Birth _____/_____/_____ Age _____

Postcode _____ Occupation _____

Are you: Male☐ Female☐ **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 does he/she 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 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.

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).