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

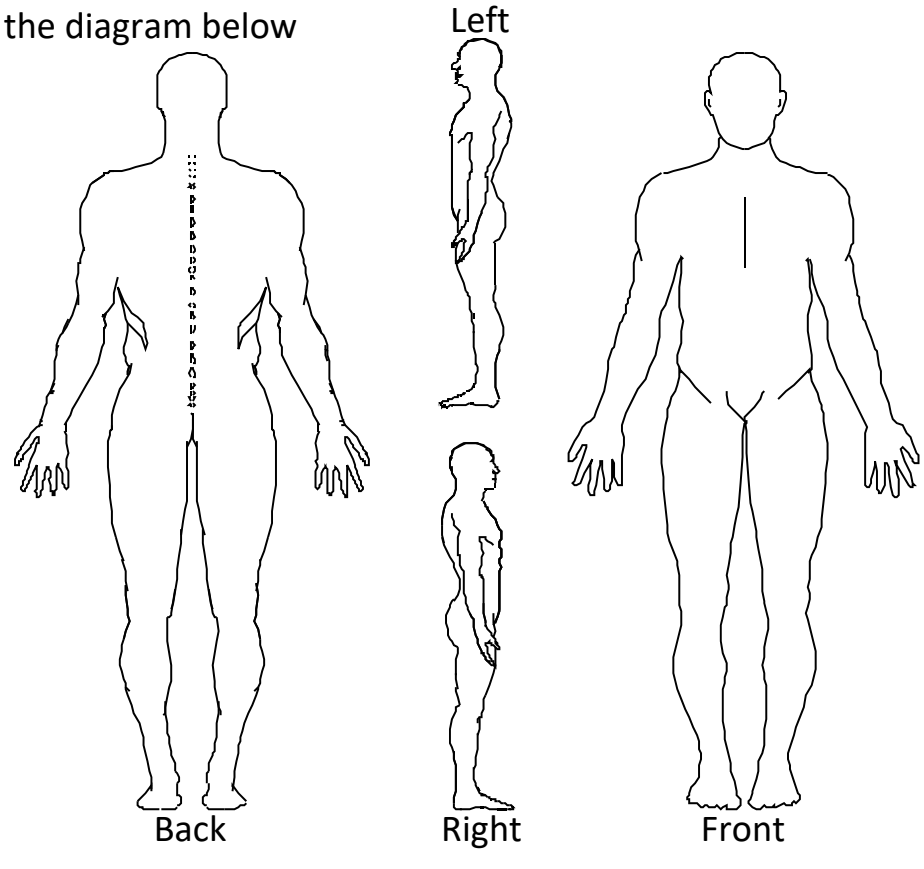
To help us identify the right approach for you we need to understand the reasons that lead you to us and what you want to achieve from your treatment in the short and long term. Therefore we ask you to spend a short time completing the form below in order to help us build an accurate picture of you and 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
List health concerns according to their severity			
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	☐ Moody ☐ Irritable ☐ Interrupt sleep ☐ Exhausted at the end of the day	☐ Moody ☐ Irritable ☐ Interrupt sleep ☐ Exhausted at the end of the day	☐ Moody ☐ Irritable ☐ Interrupt sleep ☐ Exhausted at the end of the day
Does it affect Work?	☐ Decision making ☐ Negative attitude ☐ Reduced Productivity ☐ Restrict Mobility	☐ Decision making ☐ Negative attitude ☐ Reduced Productivity ☐ Restrict Mobility	☐ Decision making ☐ Negative attitude ☐ Reduced Productivity ☐ Restrict Mobility
Does it affect Home Life?	☐ Lose your patience easily ☐ Restrict daily activities ☐ Stop or restrict exercise or sport ☐ Interfere with hobbies or activities	☐ Lose your patience easily ☐ Restrict daily activities ☐ Stop or restrict exercise or sport ☐ Interfere with hobbies or activities	☐ Lose your patience easily ☐ Restrict daily activities ☐ Stop or restrict exercise or sport ☐ Interfere with hobbies or activities
What else is this affecting?	☐ Partner ☐ Children ☐ Work ☐ Hobbies ☐ Self esteem ☐ Finances	☐ Partner ☐ Children ☐ Work ☐ Hobbies ☐ Self esteem ☐ Finances	☐ Partner ☐ Children ☐ Work ☐ Hobbies ☐ Self esteem ☐ Finances
Helping this issue would improve my quality of life by:	☐0-20% ☐30-40% ☐ 50-60% ☐70-80% ☐0.9 ☐1	☐0-20% ☐30-40% ☐ 50-60% ☐70-80% ☐0.9 ☐1	☐0-20% ☐30-40% ☐ 50-60% ☐70-80% ☐0.9 ☐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

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Ankle Swelling
☐ Angina	☐ Bladder infections	☐ Cancer	☐ Chest pains
☐ Cold sweats	☐ Chronic Thrush	☐ Constipation	☐ Cystitis
☐ Diabetes	☐ Diarrhoea	☐ Difficulty breathing	☐ Difficulty urinating
☐ Dizziness	☐ Eczema/skin problems	☐ Epilepsy/fits	☐ Eye Problems
☐ Fatigue/Tiredness	☐ Grinding teeth	☐ Headaches	☐ Heart attack(s)
☐ Hearing problems	☐ High blood pressure	☐ Indigestion	☐ Jaw pain/Clicking
☐ Joint swelling	☐ Loss of balance	☐ Loss of consciousness	☐ Loss of taste/smell
☐ Loss of vision	☐ Low blood pressure	☐ Numbness	☐ Orthodontic work
☐ Palpitations	☐ Prostate problems	☐ Pins & Needles	☐ Rapid weight loss
☐ Stroke/T.I.A.	☐ Sinus problems	☐ Teeth removed	☐ 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 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	How many children have you given birth to?		
Do you have irregular periods?	☐ No	☐ Yes	Did you experience complications	☐ No	☐ Yes
Do you have painful periods?	☐ No	☐ Yes	Have you had a caesarian section	☐ No	☐ Yes
Do you suffer from PMT	☐ No	☐ Yes	Have you had a Hysterectomy?	☐ No	☐ Yes
Are you on HRT?	☐ 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

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).