Crossgates & Rothwell
Chiropractic
Clinics

Case History Form

Crossgates & Rothwell Chiropractic Clinics Case History Form

28 Station Road, Leeds, LS15 7JY
Iveridge Hall, Wakefield Road, LS26 8EU
email: enquiries@chiropracticleeds.co.uk
Tel: 0113 260 0794 / 0113 260 0964

Surname _____ First Names _____

Date Of Birth _____ Occupation _____

Address _____

Home Tel _____ Works Tel _____

Mobile Tel _____ Email _____

Sex: Male/Female/Unspecified _____ G.p's Name _____

G.p's Address _____

G.p's Tel No _____ Consultants Name _____

Who Referred Or Recommended You To Us? _____

Insurance Company _____ Authorisation No & Excess _____

Weight _____ Height Ft _____ in _____ Recent Change Of Weight? Y / N _____

Exercise Habits And Hobbies _____

Smoker? Y / N _____ Per Day _____ Drinker? Y / N _____ Per Week _____

Medication: _____

Please do not sign the following until discussed with the chiropractor
I consent to the appropriate physical examination

Signed _____ Date _____

I have been given a report of findings regarding my condition. I have been advised of, and understand, the possible risks of the treatment and had all my questions answered to my satisfaction. I consent to treatment as outlined to me.

Signed _____ Date _____

What is your main problem? ☐ Headacheneck pain ☐ Shoulder pain ☐ Arm pain

☐ Chest / Thoracic pain ☐ Hip pain ☐ Leg pain ☐ Knee pain ☐ Foot pain ☐ Low back pain

Other _____

When did the pain start? _____

What caused the problem to start? _____

Have you experienced this problem before? ☐ Yes ☐ No How many times _____

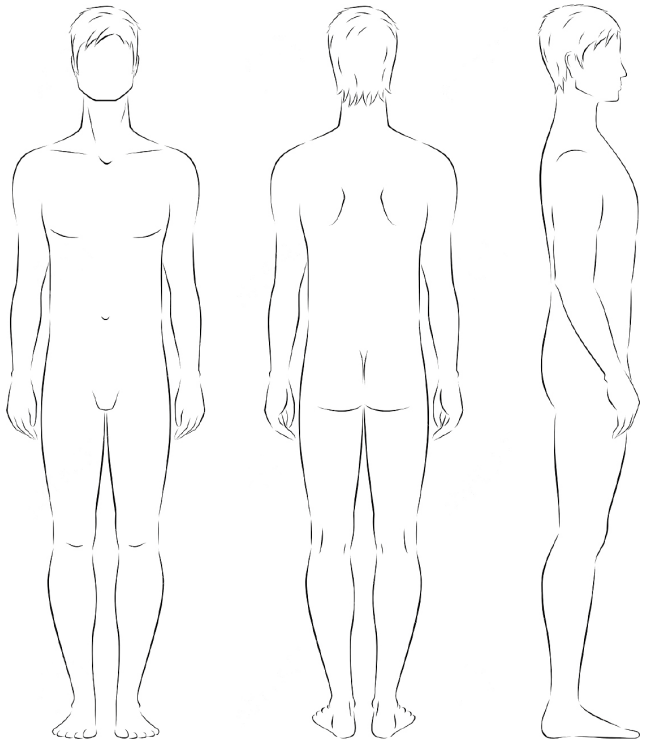
Is this the worst episode? ☐ Yes ☐ No Are the episodes getting worse? ☐ Yes ☐ No More frequent? ☐ Yes ☐ No

Approximately how often do these attacks occur? _____

The pain getting ☐ Worse ☐ Better ☐ Staying the same

Please mark the appropriate symbol (s)
on the pictures that best describes your symptoms.
Mark all affected areas.

Aching	X
Burning	=
Numbness	Z
Pins & needles	O
Stabbing	/



What makes the pain worse? _____

What eases the pain? _____

Have you lost time from work or school? ☐ Yes ☐ No Are you in litigation? ☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No ☐ Depends

Does the pain alter with change of position? ☐ Yes ☐ No

What activities do you perform at work? ☐ Bending ☐ Lifting ☐ Driving ☐ Sitting ☐ Standing

Other _____

When is the pain at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ with activity ☐ without activity

Please circle the point that most accurately describes your pain with 0 being no pain at all and 10 being the worst possible pain imaginable

Today	0	1	2	3	4	5	6	7	8	9	10
This week	0	1	2	3	4	5	6	7	8	9	10
Since the pain began	0	1	2	3	4	5	6	7	8	9	10

What treatment have you received for this problem? G.P _____

Consultant _____ Physio/osteopath _____

Other _____

What tests have you had? ☐ Xrays ☐ Blood ☐ Urine ☐ CT Scan ☐ MRI Scan ☐ Bone Scan

Do you have any other problems? _____

Accidents _____ Operations _____

Allergies _____ Fractures/dislocations _____

Major illnesses _____ Medical conditions _____

Any family history of similar condition or major illness/medical complaint _____

_____

Please highlight any of the following that you suffer with

☐ Headaches	☐ Dizziness	☐ Ringing ears	☐ Deafness
☐ Eye trouble	☐ Tremors	☐ Trouble swallowing	☐ Jaw pain
☐ Dental problems	☐ Speech problems	☐ Nervousness	☐ Depressed
☐ Mood swings	☐ Breathing trouble	☐ Chest pain	☐ Abdominal pain
☐ Bowel trouble	☐ Incontinence	☐ Difficulty urinating	☐ Nausea
☐ Skin problems	☐ Pain in reproductive organs		

Ladies: Are you pregnant? ☐ Yes ☐ No How many children have you had _____

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RISK SHEET AND PRIVACY POLICY CONSENT

Any procedure intended to help carries some risk of doing harm. While Chiropractic examination and therapeutic procedures (including spinal adjustments and mobilisations massage, trigger point release, dry needling, electrotherapy, heat and cold application and prescribed exercises) are usually considered safe and effective, please understand that occasionally there are complications. While the chances of experiencing any of these complications are small, it is the practice of this Chiropractic office to fully inform and educate all of our patients about them. These complications include but are not limited to:

Pain	Disc injury	Cold or heat burns
Swelling	Sensory Changes	Soft tissue injury
Bruising	Bleeding	Stroke (CVA)
Discolouration	Bone fracture	Dizziness
Inflammation	Nausea	Weakness
Worsening of the condition	Spinal cord injury	

I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risk associated to my care and I consent to the treatment/

I further understand and have read the clinics PRIVACY POLICY and consent for my details to be kept in accordance with them.

I am happy for the clinic contact me by ☐ phone, ☐ Text, ☐ email (PLEASE TICK BOXES) for appointment scheduling and reminders and matters relating to my care, EXCLUDING marketing.

Name: _____ Signature: _____

Parent/Guardian: _____ Signature: _____

Date: _____