Title: _____First Name: _____Surname: _____

Address:_____

_____

_____

Postcode:_____

Home Phone:_____
Mobile:_____

Email:_____

Date of Birth:_____ Gender: M or F (Please Circle)

Marital status:_____ Occupation:_____

Do you have children? Yes No (Please Circle) If yes, how many? What age(s)?

GP details and medical history

GP name:

Surgery:

Address:

When did you last see your GP?

For what reason?

Have you ever been kept in or treated in hospital Y/N

How did you hear about Optimal Align? (Tick Boxes)

GP Family/Spouse Event:

Other practitioner: Friend: Other (incl internet etc):

Please Name Event or Family/Friend who referred you:_____

Please describe the main problem with which you are attending:

_____

_____

How long have you suffered for?

_____

_____

How did it start?

_____

_____

What aggravates the condition?

_____

_____

What relieves the condition?

_____

_____

Have you ever been involved in any traffic or other trauma? (Please Circle) Yes No When?_____

Have you previously had X-Rays taken? (Please Circle) Yes No If yes, when?_____

Is there any chance you could be pregnant? (Please Circle) Yes No

Pain Rating Scale

Please circle a number from 0 to 10 rating your level of pain/discomfort (0 = no pain; 10 = the most severe experience of pain)

At best, how would you rate the level of your pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At worst, how would you rate the level of your pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
On average, how would you rate the level of your pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Today, how would you rate the level of your pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

History

Please Circle or Tick where appropriate

Have you previously seen a (Tick box) Chiropractor Physiotherapist Osteopath

If yes, what was your condition?_____

When was your last visit?_____

Have you ever had any surgery? Yes No

Please State:

_____

_____

Sports injuries, falls or broken bones? Yes No

Please State:

_____

Any hereditary family illnesses? Yes No

Please state:

_____

_____

Please circle if you have suffered any of the complaints below (please give additional details if necessary)

Allergies Arm and wrist pain Arthritis Asthma Bladder trouble Blurred vision Cancer Chest pain Colon problems Constipation Depression Dizziness Fatigue Hay fever Headaches Heart trouble High blood pressure Hip pain Indigestion Kidney problems Knee and ankle pain Leg pain Low back pain Liver problems Mid back pain Morning tiredness Muscle spasm Neck pain Nervousness Pins and needles Palpitations Poor circulation Prostate trouble Sinus problems Sleeping problems Shoulder pain Stomach problems

Other:

Women only

Heavy menstruation Painful menstruation irregular cycle

How do you rate your energy levels? High Moderate Low

How do you rate your stress level? High Moderate Low

What kind of stress? Marital Work Domestic Financial Other

How happy do you feel? 1 2 3 4 5 6 7 8 9 10

What would you like to achieve from your care?

RELIEF CARE: Symptomatic relief of pain or discomfort

CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms

COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

Consent

X-rays will be taken if deemed clinically necessary. Under law, x-rays shall remain the property of the clinic. All treatments must be paid for either in advance or on the day of the treatment. Payment can be by pre-payment plan, cash, credit/debit card. The clinic will provide you with receipts/invoices in order for you to claim any refusals from insurance companies. We reserve the right to charge for the full cost of the appointment if it is not rescheduled or cancelled within 24 hours notice of the appointment time.

I have read and understood these conditions

I consent to an appropriate physical examination

I consent to a photo to be taken with Posture Screen for postural analysis.

I consent to X-ray

If under 16 years of age this consent should be signed by a parent or guardian

Female patients only for X-ray (In accordance with policy for safe use of X-ray)

Is there any possibility that you could be pregnant? Yes/No

Are you using reliable contraception? Yes/No

What was the start date of your last period?

If yes, please specify

Reminders and Marketing Consent (please tick):

Appointment reminders ☐

We occasionally send you important marketing communications in the form of articles, special offers, health advice or newsletters ☐

I have been advised of, and understood, the possible risks of care and had all of my questions answered to my satisfaction. I consent to care as outlined to me.

Signed: _____

Date: _____

If under 16 years of age this consent should be signed by a parent or guardian