Doctors of Chiropractic:
Registered members of the
General Chiropractic Council &
British Chiropractic Association

Melanie Carpenter DC MCC
Chantelle Edmonds BSc DC MCC
Nicholas Grimshaw MChiro

Newton Abbot
Chiropractic
Centre Limited

Dear Patient—Chiropractors are primary health care practitioners specialising in the diagnosis, treatment and prevention of mechanical disorders of the Spine, Joints & Muscles of the body. To enable us to provide you with our best possible health care it is necessary for you to fill in page 1 and 2 of this registration and health questionnaire as carefully as you can. **Please ask if you have any queries. Thank you**.

PERSONAL DETAILS—Please print clearly Date: .....

Forename (s): ..... Surname: ..... Date of Birth: .....

Full Address (including Post Code): .....

..... Email: .....

Telephone numbers (incl. STD code) Home: ..... Work: ..... Mobile: .....

Marital Status: ..... Height: ..... Weight: .....

Number of children: ..... Age of children: ..... Occupation: .....

Who referred or recommended you to us? .....

Do you have medical insurance? Yes/No Which Company? .....

GP's Name and Address: .....

YOUR CONDITION

Please circle your main complaint (s): lower back, Upper back, Neck pain, Head ache, Other: .....

.....

List any minor complaint: .....

Does the pain/discomfort radiate to other areas? Leg, Arm, Head, Other: .....

When did it first start? .....

Was it a sudden or gradual onset? .....

How many episodes have you had? ..... How often? .....

Does the pain change with activity/movement or is it constant? .....

Was there an accident or cause of this condition?

Please explain: .....

.....

What is the quality of the condition? Burning, Tingling, Aching, Stabbing, Numb, Other .....

What makes it better? .....

What makes it worse? .....

When is it the worst? am, pm, evening, at night

Does the pain wake you from a sound sleep? Yes/No

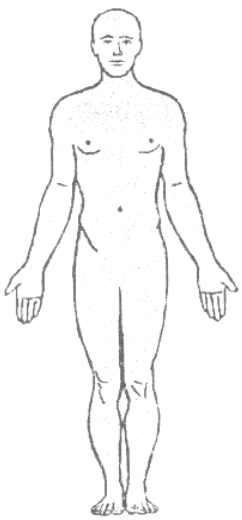
On a scale of 0-10 in which box would you put your pain Level? **X** at worst **O** at best **=** if both the same

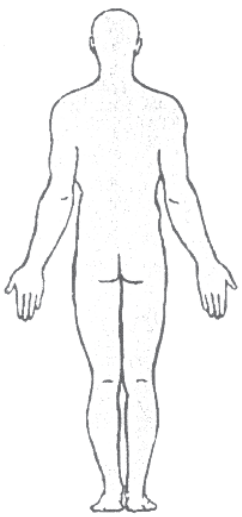
No Pain	1	2	3	4	5	6	7	8	9	10	Max. Pain

Please draw on the bodies below where your pain is and Mark type of pain using the letters:

CP = Constant Pain
P = Pain
R = Redness
S = Swelling
T = Tenderness
L = Limited movement

Name:





P.T.O.

What other specialist have you seen for this condition?

Specialist .....

Treatment .....

Result .....

What test(s) have you had for this condition? X-rays, CT, MRI, Blood, Urine, Other .....

GENERAL HEALTH CONDITION

Please tick below if you have suffered from any of the following symptoms in the last 12 months:

- □ Headaches
- □ Dizziness
- □ Loss of consciousness
- □ Double vision
- □ Ringing ears
- □ Deafness
- □ Eye trouble
- □ Trouble swallowing
- □ Jaw pain
- □ Dental problems
- □ Speech problems
- □ Tremors
- □ Nervousness
- □ Irritability
- □ Depression
- □ Breathing problems
- □ Chest pains
- □ Abdominal pain
- □ Digestive problems
- □ Bowel/bladder problems
- □ Difficulty urinating
- □ Sex organ pains
- □ Blood discharge
- □ Sudden weight loss or gain
- □ Skin problems
- □ Broken bones

WORK AND SOCIAL HISTORY

Please circle what daily activities you perform: Bending, Lifting, Sitting, Driving, Other .....

.....

Leisure/Sport/Hobby activities? .....

.....

Smoker? Yes/No ..... per day

Drinker? Yes/No ..... units per week

GENERAL MEDICAL HISTORY AND FAMILY HISTORY

Surgeries / Hospitalisation? .....

.....

Major illness / Accidents? .....

.....

Any medication taken at present? .....

.....

Do you have any other symptoms or health problems?

.....

Are you seeing any other doctor or specialist for any reason? .....

.....

Medical conditions suffered by your blood related family?

.....

.....

Is your present condition suffered by your blood related family? YES/NO

Additional space for your answers: .....

.....

GENERAL

It is Clinic policy that we contact your GP. Do you give your consent? Yes/No

(Females) Could you be pregnant? Yes/No

I consent to X-rays if required Yes/No

I consent to important treatment information being e-mailed to me and understand that I can stop this at any time

YES/NO

CONSENT TO EXAMINATION AND TREATMENT

During the consultation your chiropractor will need to perform various orthopaedic and chiropractic tests together with a physical examination of your problem area in order to establish whether we can help you or not.

Do you consent to this examination YES/NO

(This part to be completed after the consultation)

I have received adequate information regarding my chiropractic care and proposed treatment. I can confirm that, to the best of my capabilities, I understand this explanation and agree to both treatment and that any X-rays taken will remain the property of the clinic but will be released to other qualified practitioners on their request.

Signed ..... Dated .....