PETERBOROUGH CHIROPRACTIC
HEALTH & WELLNESS GROUP

WELCOME

Confidential Patient Information

Name:_____ DOB:____/____/_____ Age: ____
Address: _____ Post Code:_____
Home Phone:_____ Mobile:_____ Work: _____
Occupation:_____ Email:_____
Status: M S W D Children (No & Age):_____
GP Name and Practice:_____
Do we have permission to contact your GP: Y N
How did you hear about us? Sign ☐ Website ☐ Friend ☐ Facebook ☐ Show ☐ Other_____

Your Health Profile

Why This Form is Important: As a wellness based chiropractic clinic, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to us, and second to offer you the opportunity of improved health potential in the future. On a daily basis we are exposed to physical, chemical and emotional stresses that can accumulate and result in a serious loss to our wellbeing. Usually these effects are gradual and not even felt until the problem is serious. Answering the following questions will give us an indication of the stresses that you have faced throughout your life time, allowing us to better assess the challenges that maybe inhibiting you from expressing true health.

The Early Years (to age 16): Research is demonstrating that many of the health challenges that occur later in life have their origins during the developmental years; some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years	**YES**	**NO**	**UNSURE**
Did you have any serious falls or physical traumas as a child?	☐	☐	☐
Did you play sports in your youth?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Any prolonged use of medicines such as antibiotics or an inhaler?	☐	☐	☐
As a child were you under regular chiropractic care?	☐	☐	☐

Comments: _____

Adult (17 to present)	**YES**	**NO**	**DETAILS**
Do/Did you smoke?	☐	☐	_____ per day
Do/Did you drink alcohol?	☐	☐	_____ units per day
Have you been in any serious accidents?	☐	☐	_____
Have you had any broken bones?	☐	☐	_____
Have you had any surgery?	☐	☐	_____
Do/Have you take any medications/drugs?	☐	☐	_____
Do/Have you play any sports as an adult?	☐	☐	_____

On a scale of 1 to 10 describe your current health: (1 = poor, 10 = Excellent)

POOR 1 2 3 4 5 6 7 8 9 10 **EXCELLENT**

On a scale of 1 to 10 where would you like your current health to be: (1 = poor, 10 = excellent)

POOR 1 2 3 4 5 6 7 8 9 10 **EXCELLENT**

What do you hope to receive from treatment in this clinic?

Temporary pain relief ☐ Correction and rehabilitation ☐

Optimal muscular, skeletal and neurological health ☐

Addressing the issues that brought you to this clinic

If you have no symptoms or complaints and are here for wellness services, please tick here ☐ and then skip to the **'health profile'** box below.

What is your **chief complaint**/main reason for visiting us? _____

How long have you had this problem? _____D W M Y and does it come and go ☐ or is it constant ☐

How does it feel? Sharp/Shooting ☐ Dull/Aching ☐ Burning ☐ Numb/Tingling ☐

What makes it worse? Sitting ☐ Sleeping ☐ Activities ☐ Walking ☐

What makes it better? Pain killers ☐ Movement ☐ Rest ☐ Heat ☐ Ice ☐ other ☐_____

What is this condition affecting? Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Leisure ☐ Gym/Training ☐

Since the problem started is it: About the same ☐ Getting better ☐ Getting worse ☐

Rate your level of pain (please circle); **NO PAIN** 1 2 3 4 5 6 7 8 9 10 **SEVERE PAIN**

Have you consulted a Chiropractor, Medical Doctor or other health professional for this problem?

_____

Have you previously had diagnostic imaging? X-Ray ☐ MRI ☐ Nerve Scan ☐

Health Profile

Tick PAST (P) or CURRENT (C) if you have ever had:

P	C	
☐	☐	Headaches/Migraines
☐	☐	Dizziness/Loss of balance
☐	☐	Ringing/Buzzing in the ear
☐	☐	Menstrual pain/Irregularity
☐	☐	Changed bowel/Bladder control
☐	☐	Indigestion/Heartburn
☐	☐	Other digestive problems
☐	☐	Blood pressure problems
☐	☐	Stroke or transient ischemic attack
☐	☐	Pain/Sweats waking you at night
☐	☐	Pins & needles in arms/fingers
☐	☐	Pins & needles in legs/feet
☐	☐	Diarrhoea
☐	☐	Constipation
☐	☐	Anaemia

P	C	
☐	☐	Neck Stiffness
☐	☐	Osteoporosis
☐	☐	Fatigue/Irritability
☐	☐	Prolonged steroid use
☐	☐	Sudden/Recent weight loss
☐	☐	Sleeping problems
☐	☐	Heart disease
☐	☐	Blackouts or blurry vision
☐	☐	Increased urinary frequency
☐	☐	Cancer: _____
☐	☐	Recurrent ear/nose/throat infections
☐	☐	Asthma
☐	☐	Diabetes
☐	☐	Sexual problems
☐	☐	Thyroid disease

For Women Only (we require the following information)
Date of your last period……...
Is there any possibility of you being pregnant? (please tick) Yes ☐ No ☐

I have reviewed this questionnaire and it is accurate and truthful to the best of my knowledge. I understand that my patient records remain confidential and are protected by the clinic. This information will be used by the chiropractor to determine appropriate chiropractic examination and treatment and I consent to this. I consent to X-Rays if needed. I understand that I will be required to wear a gown for this procedure and a chaperone is available should I require one, in which case I will inform a member of the staff. I understand and agree that any appropriate X-Rays taken by the chiropractor are an important part of my permanent health records and as such remain the legal property of the clinic for a period of 8 years. The clinic is both closed and open plan and my privacy and dignity will be respected at all times by all clinic staff members. I understand and agree that I have the choice at any time as to where and how I wish to be treated by the chiropractor and I consent to this.

Signed: X_____ **Date:** _____

PATIENT CONSENT FORM

Name …… Date of Birth ……

CONSENT TO EXAMINATION

I consent to an appropriate physical examination

Signed X …….. Date …….

If you are under 16 years of age this consent must be signed by a parent or legal guardian.

Signed…….. Date …….

CONSENT TO TREATMENT

I have received the pamphlet entitled “Chiropractic Report of Findings” and I have been given a report of findings regarding my condition. I have been advised and I understand the possible risks to treatment and had all my questions answered to my satisfaction. I consent to the treatment outlined to me.

I consent to this clinic contacting my GP if deemed necessary YES ☐ NO ☐

Signed X …….. Date …….

If you are under 16 years of age this consent must be signed by a parent or legal guardian.

Signed…….. Date …….

FOR DOCTORS USE ONLY

EXAM BY _____ DATE _____

CLINICAL REASON FOR X-RAY_____

DIAGNOSIS _____

TREATMENT PLAN _____RE-EVAL _____

RED FLAGS _____ DATE _____

YELLOW FLAGS _____ DATE _____

REPORT BY _____

PETERBOROUGH CHIROPRACTIC
HEALTH & WELLNESS GROUP

Pregnancy Status Questionnaire

Patient's Name ……

DOB …….

TO BE COMPLETED BY ALL FEMALE PATINETS BETWEEN THE AGE OF 16 AND 55; GIRLS UNDER 16 YEARS OF AGE WILL ONLY BE IMAGED DURING THE FIRST 5 DAYS OF THEIR PERIOD.

To avoid irradiating an undiagnosed or early pregnancy, could you please complete this form:

1. Is there any possibility you could be pregnant? .....
2. What was the start date of your last period? .....
3. Are you using reliable contraception? ……
4. If 'yes' to the previous question please specify? ……
5. Have you had sex since the start of your last period? .....
6. Have you been sterilised (tubes cut or tied)? ……..
7. Has your partner had a vasectomy? ……
8. Have you had a hysterectomy? ……..
9. Have you gone through the menopause? ……

Please sign and date this form.

Signature X ……

Date ……

Checked ☐ Accepted / Declined

Okay to continue with examination? YES NO

Operator's signature ……

Date …….

Comments:

PETERBOROUGH
CHIROPRACTIC
HEALTH & WELLNESS GROUP

28B Priestgate, Peterborough, Cambridgeshire, PE1 1JA

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Post Code: _____

Areas Required: _____

Clinical Justification to X-Ray:

Tra ☐	50+ ☐	Neu ☐	Sco ☐	Mal ☐	UWL ☐	Art ☐
DAA ☐	Ste ☐	PYR ☐	Sur ☐	FTI ☐	EBF ☐	Pos ☐
Lim ☐	POS ☐					

☐ I have been informed of the clinical need for an X-Ray and I consent to this.

☐ I have been informed of what is involved and the possible risks.

☐ I understand that these images (made anonymous) maybe used for education purposes.

☐ I understand that X-Rays must remain the property of the clinic for 8 years.

Are you pregnant? YES ☐ NO ☐

Patient consent to X-Ray (signature): X _____

Doctor referring: _____ Date: _____

Office Use Only

Patient Name ☐ Date of Birth ☐ Address ☐

Pregnancy status checked ☐ Clinical Justification ☐

Operator's Signature: _____

PETERBOROUGH
CHIROPRACTIC
HEALTH & WELLNESS GROUP

28B Priestgate, Peterborough, PE1 1JA

X-Ray Report

Date of Exposure _____

Patient Name _____ Date of Birth _____

Area Imaged _____

Views Taken _____

Report:

Diagnosis:

Chiropractor _____