Welcome to Peterborough Chiropractic

At Peterborough Chiropractic it is our mission to help you achieve all your health goals and needs.

Whether your main reason for seeing us is to lose weight, get out of pain, increase your energy or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess and to gain an accurate understanding of where the root cause of your symptoms lie, we will be taking you through a series of examinations on your initial visit. This will include a full case history, orthopaedic and neurological assessment, postural analysis, and a functional movement assessment. These are all non-invasive and nothing to worry about we promise! Please be aware if further testing is required such as X-ray, MRI or Blood work, this will be determined by the doctor on the day and arranged by the team.

Getting ready for your visit, on the day we ask that your wear fitted clothing and something you are comfortable moving in for the physical portion of the examination, in addition to this if you have any previous X-rays or MRI reports please bring these along with you on the day for our record if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take between 30 – 40 minutes so we ask you allow sufficient time and if you have any concerns please speak to our reception before your visit if time is a constraint.

PLEASE NOTE:

We do enforce a 24-hour cancellation policy where the full fee will be charged if prior notice has not been given. If you are running late, you do run the risk of our Doctor being unable to see you, in this scenario please contact our reception staff on 01733 555 568

Confidential Patient Details

Full Name: ____ DOB: _______________ Age: _______ M ☐ F ☐

Address: ____ Post Code: __________________

Email Address: ____

Home Ph: ____________________ Mobile Ph: ______________________ Work Ph:______________________

Occupation: ___________________________ Employer's Name: _______________________________________

Status: Single ☐ Married ☐ Cohabiting ☐ Widowed ☐ Separated / Divorced ☐

Partner's Name: _________________________ Names/Ages of Children: _________________________________

Name and Practice of GP:____

Who may we thank for referring you to our office? ____

Addressing The Issues That Brought You To The Office

What brings you to us? ____

How long have you had it? _____ D/W/M/Y How did it start? ____

If you are experiencing pain is it….

Sharp/Shooting ☐ Dull/Aching ☐ Throbbing ☐ Burning ☐ Numb/Tingling ☐

Since the problem started is it….

About the same ☐ Getting better ☐ Getting worse ☐ Is it …… On/Off ☐ Constant ☐

What makes it worse? _____________________________ What relieves it? _______________________________

Yes, it interferes with: Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐

Have you had it before? No☐ Yes ☐ If yes, how often and since when? _____________________________

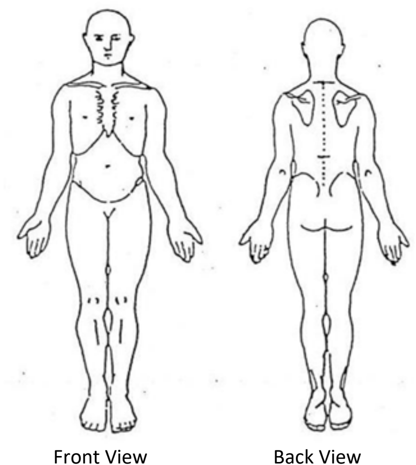
Who else have you seen for this problem? ____

Do you have any other health concerns? ____

Tick past (P) or current (C) if you have ever had:

P	C		P	C	
☐	☐	Headaches/Migraines	☐	☐	Neck Stiffness
☐	☐	Dizziness/ Loss of balance	☐	☐	Osteoporosis
☐	☐	Ringing/Buzzing in ear	☐	☐	Fatigue / Irritability
☐	☐	Menstrual Pain/Irregularity	☐	☐	Prolonged steroid use
☐	☐	Changed Bowel/Bladder Control	☐	☐	Sudden/Recent weight loss
☐	☐	Indigestion / Heartburn	☐	☐	Sleeping problems
☐	☐	Other Digestive problems	☐	☐	Heart Disease
☐	☐	Blood Pressure Problems	☐	☐	Blackouts or blurry vi sion
☐	☐	Stroke or Transient Ischemic attack	☐	☐	Increased urinary frequency
☐	☐	Pains/Sweats waking you at night	☐	☐	Cancer: ___________
☐	☐	Recurrent/Persistent sinusitis	☐	☐	Pins/Needles in arm/fingers
☐	☐	Recurrent ear/nose/throat infections	☐	☐	Pins/Needles in legs/feet
☐	☐	Asthma	☐	☐	Diarrhoea
☐	☐	Diabetes	☐	☐	Constipation
☐	☐	Fainting	☐	☐	Sexual problems
☐	☐	Anaemia	☐	☐	Thyroid disease

Mark / label all areas of pain, stiffness or abnormal sensation:



Front View Back View

On the diagram above:-

A. What number do you think represents your health today?____

B. In what direction is your health currently heading? ____

Have you had any spinal x-rays taken in the last 12 months? No ☐ Yes ☐

Please state any major illnesses or any surgeries and years: ____

____

List traumas (Car-whiplash/home/sports/work injuries etc.) and years: ____________________________________

____

Family Health Profile:

At Peterborough Chiropractic we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones.

Do you or any of your family suffer from?

Diabetes ☐ Heart problems ☐ Stroke ☐ Epilepsy ☐ Cancer ☐ Orthopaedic Problems ☐

Please mention below any other health conditions or concerns you may have about family members:-

Children ☐ Spouse ☐ Mother ☐ Father ☐ Brothers ☐ Sisters ☐ Others ☐

____

Female Clients:-

Are you currently pregnant? No ☐ Yes, I am due ____________ Number of past pregnancies? ________

Have you any health concerns regarding this pregnancy? ____

Allergies, Medications & Supplements

Allergies (list)	Medications (list)	Supplements (list)
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

DECLARATION: This information is accurate to the best of my knowledge. My signature below will also serve as consent for any examination procedures deemed appropriate/necessary by the chiropractor.

Signature: (parent/guardian to sign for minors):____

Date:________________________

PETERBOROUGH
CHIROPRACTIC
HEALTH & WELLNESS GROUP

Medical Symptoms Questionnaire

Name: ____ **Date:** ____________________

Rate each of the following symptoms based upon your typical health profile for : ☐ **Past 30 days** ☐ **Past 48 hours**

Point Scale: 0- Never or almost never have the symptom. **1**- Occasionally have it, effect is not severe.

2- Occasionally have it, effect is severe. **3**- Frequently have it, effect is not severe. **4** – Frequently have it, effect is severe.

HEAD

___Headaches

___Faintness

___Dizziness

___Insomnia **Total:___**

EYES

___Watery or Itchy eyes

___Swollen, reddened or sticky eyelids

___Bags or dark circles under eyes

___Blurred or tunnel vision

(Does not include near or far sighted

Total: ___

EARS

___Itchy ears

___Earaches / Ear infections

___Drainage from ears

___Ringing in ears / Hearing loss

Total: ___

NOSE

___Stuffy nose

___Sinus problems

___Hay fever

___Sneezing attacks

___Excessive mucus Formation

Total:___

ENERGY / ACTIVITY

___Fatigue/ Sluggishness

___Apathy / Lethargy

___Hyperactivity

___Restlessness **Total:___**

WEIGHT

___Binge eating / Drinking

___Craving certain foods

___Excessive weight

___Compulsive eating

___Water retention

___Underweight **Total: ___**

EMOTIONS

___Mood swings

___Anxiety / Fear / Nervousness

__Anger / Irritability / Aggressiveness

___Depression **Total:___**

MIND

___Poor memory

___Confusion / Poor comprehension

___Poor concentration

___Poor physical condition

___Difficulty in making decisions

___Stuttering / Stammering

___Slurred speech

___Learning disabilities **Total:___**

LUNGS

___Chest Congestion

___Asthma, Bronchitis

___Shortness of breath

___Difficulty breathing

Total:___

HEART

___Irregular or skipped heartbeat

___Rapid or pounding heartbeat

___Chest pain

Total:___

DIGESTIVE TRACT

___Nausea / Vomiting

___Diarrhoea

___Constipation

___Bloated feeling

___Belching / Passing gas

___Heartburn

___Intestinal / Stomach pain

Total: ___

OTHER

___Frequent illness

___Frequent or urgent urination

___Genital Itch or discharge

Total:___

MOUTH / THROAT	SKIN	JOINTS / MUSCLE
___Chronic coughing	___Acne	___Pain or Aches in joints
___Gagging / Frequent need to clear throat	___Hives / Rashes / Dry Skin	___Arthritis
___Sore throat / Hoarseness / Loss of voice	___Hair loss	___Stiffness or limited movement
___Swollen or discoloured tongue / Gums / Lips	___Flushing / Hot flashes	___Pain or Aches in Muscles
___Canker sores	___Excessive sweating	___Feeling of weakness or tiredness
Total:___	**Total:___**	**Total:___**
		GRAND TOTAL:_________________

I authorise Peterborough Chiropractic to contact me by the following,

I am aware I can opt out at any time, please initial to opt IN for the following:

- Letter _________
- Telephone _________
- Email _________
- Social Media _________

I am happy to continue chiropractic treatment, at the following schedule

Sign…………………………………. Date……………………………………

Office use only

Health Satisfaction assessment

Name: ____ Date: _____________________

Email address: ____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

Physical Health:

I am a physically fit person and formally exercise on a regular basis. 1 2 3 4 5 6 7 8 9 10

I have a physically attractive body that I am proud to look at in the mirror. 1 2 3 4 5 6 7 8 9 10

I have not had any traumas in my life (auto accident, broken bones, bad falls). 1 2 3 4 5 6 7 8 9 10

I get at least 7 hours of sleep a night, 7 days a week. 1 2 3 4 5 6 7 8 9 10

I have had regular Chiropractic care within the past 5 years. 1 2 3 4 5 6 7 8 9 10

Total:_____

Emotional Health:

I am a calm, peaceful person. I can shut my mind off and focus my mind at will. 1 2 3 4 5 6 7 8 9 10

I can practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis. 1 2 3 4 5 6 7 8 9 10

Most of the time, I am truely happy and feel some sense of purpose in my life. 1 2 3 4 5 6 7 8 9 10

I have healthy relationships and a rich social network of friends and activities. 1 2 3 4 5 6 7 8 9 10

I am organised, have time for myself, and can prioritise the important tasks in my life. 1 2 3 4 5 6 7 8 9 10

Total:_____

Chemical / Nutritional Health:

I eat 4 – 6 small meals daily and properly combine my protein, carbs and fats. 1 2 3 4 5 6 7 8 9 10

I supplement everyday with good supplements such as vitamin/ mineral complex, antioxidants and good fatty acids (fish oil, flax seeds etc). 1 2 3 4 5 6 7 8 9 10

I do not take medications for chronic medical problems such as digestive disorders, cardiovascular problems, headaches, chronic pain, blood sugar problems, chronic fatigue, immune problems or chronic infections, or any other chronic conditions. 1 2 3 4 5 6 7 8 9 10

I do not smoke cigarettes. 1 2 3 4 5 6 7 8 9 10

I drink water as my primary beverage and consume at least 2 litres a day. 1 2 3 4 5 6 7 8 9 10

TOTAL:_____

Total of all 3 (Physical, Emotional and Chemical) sections: _____