PETERBOROUGH
CHIROPRACTIC
HEALTH & WELLNESS GROUP

28B Priestgate Peterborough PE1 1JA 01733 555568

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 and a £15 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

PETERBOROUGH CHIROPRACTIC
HEALTH & WELLNESS GROUP

28B Priestgate Peterborough PE1 1JA 01733 555568

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? _____

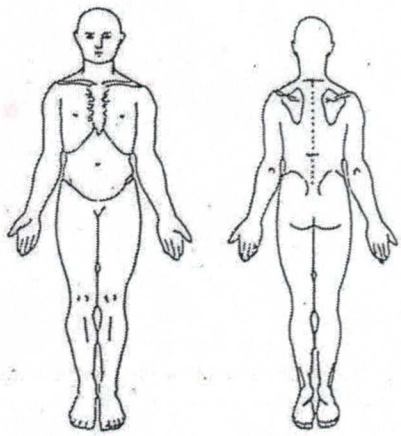
Who else have you seen for this problem? _____

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)
_____	_____	_____
_____	_____	_____
_____	_____	_____

We do have a 24-hour cancellation policy, anything within the 24-hours will incur a £15 fee.

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

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: _____

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

Consent to Examination

I consent to an appropriate physical examination

Name.....**Date**.....

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

Name.....**Date**.....

Consent to treatment

I have been advised by the chiropractic doctor, I understand the possible risks to treatment and have had all my questions answered to my satisfaction. I give consent to the treatment outline to me.

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

Name.....**Date**.....