



# Newquay Chiropractic Clinic

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## CONFIDENTIAL PATIENT QUESTIONNAIRE

IT IS **ESSENTIAL** THAT THE FIRST TWO PAGES ONLY ARE COMPLETED IN **FULL BLOCK CAPITALS**

### PERSONAL DETAILS

Today's Date:

Surname:	Title: Mr/Mrs/Miss/Dr	Age:
Forename(s):		Date of birth:
Address:	Number of children & ages:	
	Occupation:	
	Height:	Weight:
Postcode:	E-mail:	
Tel (home):	Mobile:	Tel (work):
GP's name & address:		
How did you hear about us? (Please include name if referred by friend/family/colleague)		
Do you have medical insurance? <b>Yes / No</b> . Which company?		

### CHIEF COMPLAINT & HISTORY

Main complaint:

When was the first time you noticed pain in this area?

Describe the **character/type** of pain:

On a scale of 1-10(severe), how bad is your worst pain..... and generally.....?

Has the complaint got **worse**, stayed the **same**, or got **better** since it started?

What makes it **worse**?

What makes it **better**?

Have you had any previous spinal treatment? **Yes / No**

Please shade in areas of the adjacent diagram:

**Pain** with:           xxxxx

**Tingling** with:     ooooo

**Numbness** with:   :~::~:~::~:

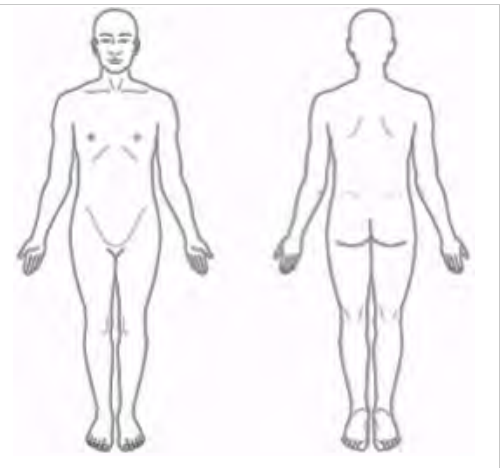
Have you lost weight for no apparent reason? **Yes / No**

Have you had night sweats? **Yes / No**

Have you had any change in bowel or bladder function? **Yes / No**

Please advise of any medication / pain relief you may be taking:

Any previous related tests? (X-rays, MRI, blood tests, urinalysis etc.)



**Medical History:** Can you please give details of your **general health** e.g. any recent changes, any past or present medical conditions? Are you currently receiving any **medical / NHS** care?

Do you smoke?.....per day

Do you drink?.....units per day (1/2 pint=1 unit)

	Self	Family		Self	Family
Allergy & skin disorders			Hiatus hernia		
Alcoholism			Heart disease / Stroke		
Asthma			HIV / Hepatitis		
Blood pressure			IBS		
Cancer			Mental illness		
Diabetes			Osteoporosis		
Epilepsy			Prostate		
Goitre / Thyroid			Rheumatic fever		
Glandular fever			TB		
Headache / Migraine			Other?		

Do you exercise? **Yes / No** If yes what type?.....How often?.....per week

Please give details and the dates of any previous Road traffic accidents, sports injuries, surgery or major illness:

**PSYCHOSOCIAL HISTORY**

Do you consider yourself under stress?

	Home	Work
Mild		
Moderate		
Severe		

Newquay & Kernow Chiropractic Clinics are aware of its obligations under the General Data Protection Regulation (GDPR) and is committed to protecting the privacy and security of your personal information. Please see our website for full details or in our clinic.

In case of treatment to a minor, or a patient who is recognised to have diminished intellectual capacity, this consent is to be signed by either parent or legal guardian. A Chaperone is available on request. Please ask if you wish to have one present.

Finally, please be aware that the clinic will need **24-hour notice to cancel appointments**. Unfortunately there is a 50% charge for appointments cancelled within 24 hours or for missed appointments.

**I confirm that I have read and understood the Privacy Statement and give my consent for the clinic to maintain my records for the purpose outlined in that statement.**

**Occasionally we may wish to contact you with information about the clinic and upcoming events or topics. We will never share your details with any 3<sup>rd</sup> parties.**

<b>May we email you if needed regarding:</b>	<b>Contact discussing appointments/treatment</b>	<b>YES/NO</b>
	<b>Clinic events &amp; updates</b>	<b>YES/NO</b>

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

