

The Chiropractic Centre

9A GEORGE ST, CROYDON, CR0 1LA, 020-8680-4777

NEW PATIENT QUESTIONNAIRE

IMPORTANT - PLEASE READ CAREFULLY

For us to fully understand your condition, we require a complete description of not only your present symptoms but also your overall health pattern, both past and present. This valuable information will help us to better evaluate your problem and it will determine what type of response to chiropractic we can expect from your body.

Thank you

HOW WERE YOU REFERRED TO THE CENTRE? Please write the name of the individual if applicable.

Family member: _____

Friend: _____

Chiropractor / GP: _____

Other: _____

Yellow Pages

UCA

Chiropractic Lecture

Clinic Sign A-board

CONFIDENTIAL PATIENT CASE HISTORY

Name (In full): (Mr/Mrs/Miss) _____

Date of Birth: _____ Age _____ Telephone _____

Address: _____ Home (_____) _____
_____ Work (_____) _____
_____ Mobile (_____) _____
_____ Email _____

Post Code: _____

Occupation (Current) _____ (Previous) _____

Marital Status: _____ Spouse's name: _____

Children's names and ages, please mention any health concerns:

_____ Age: _____ Concerns: _____
_____ Age: _____ Concerns: _____
_____ Age: _____ Concerns: _____
_____ Age: _____ Concerns: _____

GP or surgery name: _____

Do you have private medical insurance? _____

Does it cover Chiropractic: Yes No

Are you making an insurance claim? Yes No

PREVIOUS CARE

Chiropractor Osteopath Physiotherapy Other

Name of Practitioner: _____ Location: _____

Reason for attending: _____

How many visits: _____ How frequent: _____

When did you last attend: _____

What was your response

Excellent Good Fair Poor No change Worse

Have you had X-rays taken? Yes No

When were they taken? _____ Where were they taken? _____

PRESENT CONDITION

Please describe your present complaint or symptom: _____

Have you had this before? Yes No If yes when _____

When did the problem start this time? _____

What, do you feel, caused the condition this time?

Fall Stress Car Accident Strain Lifting Don't know

How have your symptoms changed since their onset?

Getting worse Staying the same Getting better Come and go

Have you consulted anybody else about your current condition? Yes No

If so who? _____ When? _____

Are you currently taking any medication? Yes No

Pain killers Relaxants Nerve pills Birth control

Other (please specify) _____

PREVIOUS, CURRENT AND FAMILY HEALTH

Have you ever had a serious health problem?

Have you had any operations or been hospitalised for any reason?

Have you broken any bones or been involved in a major trauma such as a car accident?

Please specify what injuries were sustained and when it occurred.

Are there any heritable conditions in your family (e.g. heart disease, cancer, arthritis, diabetes)

PATIENT IN-DEPTH SYMPTOM SURVEY

Please answer these questions about your general health. The information may seem unimportant to you and not related to your complaint but it will give your Doctor a more complete understanding about your body's overall function.

Please tick any of the following symptoms or problems you have had and underline any that presently bother you.

<i>Occasionally</i>	<i>Frequently</i>	<i>Constantly</i>		<i>Occasionally</i>	<i>Frequently</i>	<i>Constantly</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ring/buzz in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder troubles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Female problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper back problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid back problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg pains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling

Occasionally	Frequently	Constantly		Occasionally	Frequently	Constantly	
			Headaches				Palpitations
			Dizziness				High blood pressure
			Blurred vision				Low blood pressure
			Depression				Heart trouble
			Nervousness				Stomach trouble
			Sleeping problems				Indigestion
			Morning tiredness				Liver problems
			Energy loss				Colon problems
			Ring/buzz in the ears				Constipation
			Fainting feeling				Kidney problems
			Sinus problems				Bladder troubles
			Allergies				Female problems
			Neck pain				Prostate trouble
			Neck stiffness				Low back pain
			Shoulder problems				Low back stiffness
			Upper back problems				Hip problems
			Mid back problems				Leg pains
			Chest pain				Tingling

Do you have any other problems that the Doctor should know about?

DISCLAIMER

I understand that the information, written or otherwise, is given in the strictest confidence. This information will be kept for a minimum of seven years in our records. No information or patient records will be released to any person, health fund, insurance company or other doctor without my written consent. All X-ray films will remain the property of The Chiropractic Centre. I clearly understand and agree that all services are charged to me and I am personally responsible for payment. Fees are due at the time of visit, including Xrays and or examination. I also understand and agree that health, accident, insurance policies are an arrangement between the insurance company and myself, therefore I am personally responsible for any outstanding payment that I am unable to claim through my insurance policy.

I give consent to historical, physical, and X-ray examinations necessary and to provide care by the Chiropractor as they deem appropriate. The practitioner will not be held responsible for any pre-existing medically diagnosed conditions or any medical diagnosis. The statements on this form are accurate to my best recollection

Patient's or parent / Guardian's Signature _____ Date _____