Name:_____ Preferred Name_____ Date : _____

Date of Birth: _____Age _____ E -Mail: _____

Mobile Telephone : _____ Home Telephone :(_____) _____

Address:

_____

_____Postcode:_____

Spouse's Name: _____ Children's Names & ages:_____

Occupation: _____

Type of work: □ Sitting □ Computer □ Standing □ Driving □ Lifting

GP Name & Surgery: _____Permission to contact if required: Yes / No

How did you hear about us? _____

Have you ever been to a chiropractor Osteopath Physiotherapy Massage before? □ Yes □ No

How was the results _____ Did you have x-rays? □ Yes □ No

Health Conditions

Have you had any operations, been hospitalised for any reason or suffer from any other current health conditions, please list ALL previously diagnosed conditions including any inflammatory condition such as rheumatoid arthritis, gout or osteoporoses or cancer.

_____

_____

Have you broken any bones or been in a trauma e.g. a car accident/fall/knock/ injury or are there any hereditary health conditions? If so please specify the injuries that were sustained/ when it occurred/ hereditary conditions.

_____

Are you currently taking any medication? Yes □ No □

If yes, please name the medication or the reason you have to take them.

_____

_____

Is there any other information you would like to tell the chiropractic doctor**?**

_____

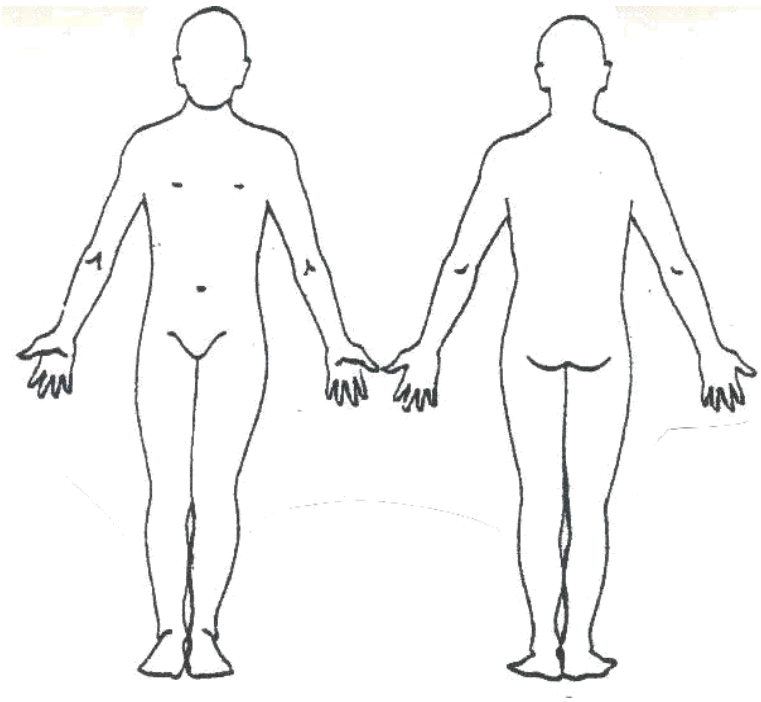
Why have you come to see us today?

Please list your health concerns in order of their severity:	How long have you been noticing it for?	What do you think caused this problem?	% of the time pain is present	Is the pain getting worse?
1)				
2)				
3)				

Please mark areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
_____	OOOOOOOOO	XXXXXX	********	///////////

PAIN CHART:



Neck/Shoulder/Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Does this Cause you to Be:	**Does this affect your Work:**	**Does this affect your life:**
□ Moody	□ Decision Making	□ Lose patience with your family
□ Irritable	□ Poor attitude	□ Restricted household duties
□ Interrupt sleep	□ Decreased Productivity	□ Can't exercise or play Sport
□ Restrict your daily activities	□ Exhausted at end of Day	□ Interference with hobbies/activities

YOUR HEALTH GOALS

The purpose of this section is to enable your chiropractor to know what your health objectives are, what your expectations are and what is important to YOU. **(Please tick your answer)**.

Are you happy with the way you look and feel?	□ Yes	□ No	
How long has it been since you have felt your best?	□ Years	□ Months	□ Days
How long have you been thinking about pursuing your health goals?	□ Years	□ Months	□ Days
How long do you think it will take to achieve your health goals?	□ Years	□ Months	□ Days

Circle ONE number for EACH of the following statements that best describes your painful complaint and how it is affecting you NOW. Please read each question carefully before answering.

Over the past few days, on average, how would you rate **your pain** on a scale where '0' is 'no pain' and '10' is 'worst pain possible'?

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, on average, how has your complaint interfered with **your daily activities** (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair,sleeping) on a scale where '0' is 'no interference' and '10' is 'completely unable to carry on with normal daily activities'?

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, on average, how much has your painful complaint interfered with your normal **social routine** including recreational, social and family activities, on a scale where '0' is 'no interference' and '10' is 'completely unable to participate in any social and recreational activity'? X

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, on average, **how anxious** (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where '0' is 'not at all anxious' and '10' is 'extremely anxious'?

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, **how depressed** (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where '0' is 'not at all depressed' and '10' is 'extremely depressed'?

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, how do you think **your work** (both inside the home and/or employed work) have affected your painful complaint, on a scale where '0' is 'make it no worse' and '10 is 'make it very much worse'?

0 1 2 3 4 5 6 7 8 9 10

Over the past few days, on average, how much have you been able to control (help/reduce) and **cope** with your pain on your own, on a scale where '0' is 'I can control it completely' and '10' is 'I have no control whatsoever'?

0 1 2 3 4 5 6 7 8 9 10

Personal Informed Consent and our Data Protection Policy

I give my consent to an appropriate physical examination, x rays and treatment if necessary.

I have received the welcome pack which includes the fee scale.

Chiropractic is recognised as being an effective and safe form of healing. In fact, due to the wonderful results, chiropractic is the largest drug-free health care profession in the world.

We want to inform you of the possible risks associated with chiropractic care.

1. You will be tested before any adjustments are applied;
2. Sometimes you may get **pain**, a strain to a ligament or disc, or an aggravation of the underlying condition from a perfect adjustment. This may happen just like a good massage or gym session. If this occurs please call straight away, there are things your Chiropractor can do to help. If this occurs you may even require a 2nd adjustment. We **never charge if you need a 2nd adjustment on the same day.**
3. Accidents are extremely rare and the risk of damage to neck blood vessels, which can arise in stroke or like symptoms.
4. Chiropractic adjustments of the spine are internationally recognised as being far safer than medications and many other alternatives.
5. I acknowledge the above information and do not expect the Chiropractor to be able to anticipate all potential risks and complications. Based on all the information provided.

PERSONAL INFORMATION: We use this information to assist and help us identify any condition which could affect your treatment.

INFORMATION SHARING: We do not share your patient records or personal information with any third parties, insurance company or other Doctor without your consent, unless we are required by law to do so.

MARKETING COMMUNICATIONS: You will not receive any marketing from this clinic.

We send out appointment reminders via text. Please advise us if you do not want to receive them.

SIGNATURE_____ **DATE** _____

PLEASE STOP HERE LEAVE FINAL PAGE UNTIL YOUR RESULTS

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

OFFICE POLICIES & CONSENT ONLY IN OFFICE PLEASE

• To get the time that you prefer, please pre-schedule all appointments if possible.	
• There are 2 types of appointments - adjustments and long visits. • If you have any injuries, accidents or have questions for Dr Harvey, simply call the clinic to book a longer time.	☐
• Avoid missing appointments. We operate a make up misses. (MUM) • We will text you the working day before your appointment.	☐
• If you are going away on holidays during your treatment, your adjustment plan may increase in frequency, for the week before, and after you are away.	☐
FAMILIES • Scoliosis or posture problems are common and can run in families and may go undetected. We would like to offer a full examination to family or friends within 14 days at a reduced fee voucher £29.00. We also recommend attending a spinal workshop to help educate and prevent relapses saving time and money in the future.	☐ ☐

ADJUSTMENT PLAN **Frequency:**	_____ wk for _____ weeks visit by visit to start with ☐ **PAYMENT PLAN** Pay as you go ☐ Prepay ☐ 12 VISIT ☐ 24 VISIT ☐

PATIENT CONSENT

I have received a full explanation of my condition including differential diagnosis. ☐

I have had the opportunity to ask questions and received and read the welcome folder. ☐

I have been advised of treatment options and the likely benefits. ☐

I understand some symptoms may increase and that soreness after treatment

is normal. Acupuncture and massage sometimes can cause bruising.

However, if this continues a more gentle non-force treatment will be recommended. ☐

I understand that a full reassessment and review will be performed at 12 visits. ☐

I am aware that I can book a review at any time if concerned about my progress. ☐

I have been advised of possible side effects and risks associated with treatment & ☐

I consent to chiropractic treatment in open rooms and I am aware that

private or closed rooms are available at my request. ☐

I understand that although we cannot give guarantees' we will be working for your best interests. ☐

I have read and understood the fees and DNA charges, refunds, and the above office policies consent form. ☐

A refund of any outstanding balance will be refunded on request. ☐

PATIENT: .....

DC/CA: .....

DATE: .....