Name:

CAMDEN CHIROPRACTIC

CONSULTATION FORM

Surname: ……..…….. Forename(s): ……..…… DOB: …..…..…… Age: …..

Address & Postcode: ……

Home Tel: …… Mobile: ……..…… Email: ……..…...

GP Name & Practice: ……

No. & Age of Children: …… Marital Status: S M D W

Is there a chance you could be pregnant? Yes ◯ No ◯

Occupation: …… Who referred you to us: ……...……

Your motivation for visiting us today: ……....

……...

YOUR SPINE IS UNIQUE TO YOU AND IS VITALLY IMPORTANT TO YOUR OVERALL HEALTH, THIS IS WHY OUR CONSULTATIONS ARE FOCUSED ON YOU AND ABOUT YOUR LIFESTYLE.

The following questions will help your Chiropractor assess any layers of damage, particularly to your nervous system, that may have adversely affected your health. All information you supply will be handled in the strictest confidence.

YOUR GENERAL HEALTH

List any medications that you take (and why): ……

List any surgery (operations) you have had: ……

List any major accidents or falls: ……

Have you been treated for any other health condition in the last year? Yes ◯ No ◯

If yes, please explain: ……...

Please tick any of the following which you find are affected by your pain:

◯ Sleep ◯ Mood ◯ Work ◯ Family Life ◯ Leisure Time

What is your usual sleeping posture? ◯ Side ◯ Stomach ◯ Back

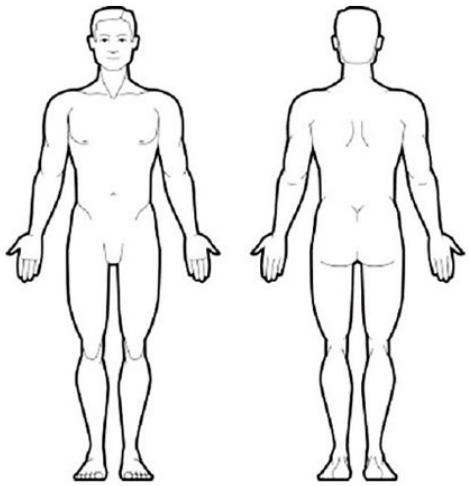
How many units of alcohol do you drink weekly? ◯ None ◯ 1-20 ◯ 20+

Do you smoke? ◯ Yes ◯ No If yes how many per day? ……

GOALS & MOTIVATION:

Drive your car / play tennis etc? …….

Please outline areas of pain/discomfort



ABOUT YOUR PAIN:

What aspects of your health currently concern you?……..…

How would you rate your pain/discomfort?
(1 = No Pain & 10 = Extreme pain) 1 2 3 4 5 6 7 8 9 10

How would you rate your current state of mental health?
(1 = Poor & 10 = Excellent) 1 2 3 4 5 6 7 8 9 10

How would you rate your general health?
(1 = Poor & 10 = Excellent) 1 2 3 4 5 6 7 8 9 10

DO YOU OR HAVE YOU EVER SUFFERED WITH:

○ Rapid weight loss	○ Dizziness	○ Cancer	○ Prostate problems
○ Stroke/TIA	○ Heart attacks	○ Epilepsy/fits	○ Loss of consciousness
○ Blood pressure +/-	○ Chest pain	○ Palpitations	○ Shortness of breath
○ Infection	○ Asthma	○ Cystitis	○ Urinary tract infection
○ Difficulty swallowing	○ Incontinence	○ Diabetes	○ Eczema/skin disease
○ Constipation	○ Diarrhoea	○ Indigestion	○ Arthritis/joint swelling

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YOUR CONSENT

I hereby give consent to undergo a clinical examination and for my personal data to be recorded.

Signed: …… Date: ……

I consent to receiving treatment from the Chiropractor following a clear explanation of the treatment and any risk involved.

Signed: …… Date: ……