DATE
DR
EMAIL
GP LETTER
X-RAY

YOUR DETAILS

Full Name (Mr/ Mrs/ Ms/ Miss/ Dr) ……...

Full Address……..……...…….

……

Date of Birth ....…...……....…… Occupation……..…….....

Mobile……..…… Other……..……..……

Email.…….....…….……...

It is our policy to write to your GP regarding your health; do you give consent? ○ yes ○ no

GP's Surgery Address.…….....

……...

REFERRAL DETAILS

How did you hear about our practice?

○ Recommendation *(please specify name)*.…….....….

○ Passing by ○ Internet *(please specify)*.....…….……..…….....

○ Advert *(please specify)*..……...…….....

YOUR HEALTH HISTORY

Do you or have you ever smoked? ○ no ○ yes, how long…….....…How many per day.....

Do you take regular exercise? ○ no ○ yes, please detail……..…...…….

Do you have a particular diet? ○ no ○ yes, please detail……..…...

Please name any medications you are taking: ……..…….....

……...……...……

Are you taking any steroids (or have in the past for more than 8weeks)? ○ no ○ yes (specify)…….

Please mention any illnesses, diseases or conditions you have……..……..

……..……..……..……..……

Have you had any surgery? ○ no ○ yes; please detail……..…

……

Please describe any previous physical trauma (e.g. falls, car accidents, fights etc) ……

.....

Please detail any major illnesses in your family ……...……...…...…..

……...

This form continues, please turn the page

HISTORY OF CURRENT CONDITION

List your main complaint and other complaints/symptoms in order of severity:

1……..…… Started? ..... Cause ….……..…….

2…….... Started? ..... Cause ….……..…….

3…….... Started? ..... Cause ……..……..……

Regarding your chief complaint

Is it (*please tick)* ○ getting worse ○ improving ○ constant ○ intermittent ○ can't say

Is your pain ○ sharp ○ stabbing ○ throbbing ○ shooting ○ dull

○ toothache ○ other *(describe)*……..…..…….....

Do you feel ○ cramps ○ burning ○ swelling ○ stiffness ○ tingling

○ numbness ○ other *(describe)*...……

What makes it worse? 1..... 2..... 3.....…….

What eases it? 1……2……...… 3…….....

Have you had previous episodes similar to this? ○ no ○ yes; when? ……..…….....

Please tick if you had X-rays/scans (last 5yrs)? ○ no ○ yes; why? ……..…….

Have you consulted your GP, or received treatment regarding this complaint? ○ no ○yes; *(describe)*…

……..…….

FOR WOMEN ONLY

Are you pregnant? ○ no ○ yes; how many months?..... Previous (detail)…….....

Had your menopause? ○ no ○ yes; at what age?..…… Had a hysterectomy? ○ no ○ yes

Have you taken HRT ○ no ○ yes; for how long? .....

EXAMINATIONCONSENT

I ..... confirm that I agree to any examinations including X-rays that are deemed necessary to my case. I understand that X-rays or other diagnostic tests undertaken by this clinic remain the property of Chiro First Clinics®, and will only be released to other parties with my prior agreement. I understand that the clinic will store my personal information on its database and may contact me from time to time. This does not affect my rights under the Data Protections Act.

(In the case of examination of a minor, or a patient recognised to have diminished intellectual capacity, this consent is to be signed by either parent or legal guardian, this fact being appropriately noted below)

Signed..... Date.....