Date: Pt #:

pure chiropractic

CONFIDENTIAL PATIENT RECORDS

Thank you for choosing our clinic. You have placed a trust in us that we value very highly.
All the information provided in these forms will be kept private and confidential.
Please take a moment to fill out the following details:

Personal Details

First names:_____ Surname:_____

Title: Mr / Mrs / Miss / Ms / Other _____ Date of Birth:_____ Age:_____

Address:_____

_____ Post code:_____

Telephone: Home:_____ Marital status:_____

Work:_____ No. of children:_____

Mobile:_____ Ages of children:_____

E-mail:_____

Occupation:_____ Hobbies:_____

How were you referred to Pure Chiropractic:

☐ internet ☐ yellow pages book ☐ newspaper advert ☐ signage ☐ GP
☐ screening ☐ Thomson directory ☐ family/friend ☐ other_____

Do you have Private Health Insurance: ☐ yes ☐ no Insurer name:_____

General Health Information

GP Name:_____ GP Tel:_____

GP Add:_____

Date of last GP visit:_____ Reason for visit:_____

Do you/have you had any major health problems or operations: ☐ yes ☐ no

If yes, please describe:_____ Date:_____

List any medications and/or supplements you are **presently** taking:_____

_____

List any medications you have taken for long periods in the **past**:_____

_____

Are you a smoker: ☐ yes ☐ no ☐ previously

If yes, how many per day_____ and for how long_____

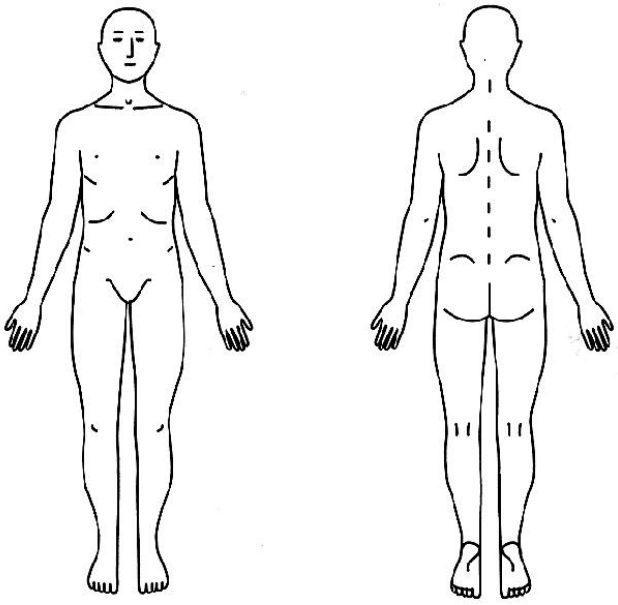
Do you drink alcohol: ☐ yes ☐ no

If yes, how many units per week_____

Please turn over

Your Health Profile

Please shade the area(s) of complaint in the diagram below:



On this scale from 0 – 10 please grade your pain by circling the appropriate box:

0	1	2	3	4	5	6	7	8	9	10

Please tick box (if you currently or have previously suffered from any of the following):

Symptoms	Yes	No	Symptoms	Yes	No
Cancer (past/present)			Headaches		
Heart condition			Blurred vision		
High blood pressure			Dizziness		
Stroke			Sinus problems		
Blackout/faints			Ringing in ears		
Chest pain			Abdominal pain		
Chronic cough			Trouble urinating		
Asthma			Prostate problems		
Diabetes			Menstrual problems		
Thyroid problems			Allergies		

Have you ever broken any bones? Yes / No
Have you ever been in a road traffic accident? Yes / No
Have you had any x-rays or scans of the current area of pain? Yes / No

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I understand that 24 hours notice must be given to change or cancel an appointment. Missed appointments or late cancellations will incur a £10 charge. I give my consent to a consultation, physical examination and, if appropriate, relief treatment. I accept that my clinic records will be held by the clinic. I understand that my GP will be advised of any treatment I receive at the clinic. I have read, understood and accept the terms of the Practice Policy (v6.5).

Signature:_____ **Date:**_____