Case History Form ***Patient Name:*** …….. ***Date:*** ……/……/……

1. What is your main complaint? Please mark it on the diagram

……
……
……
……
……

2. When did it start?

……
……

3. How did it begin?

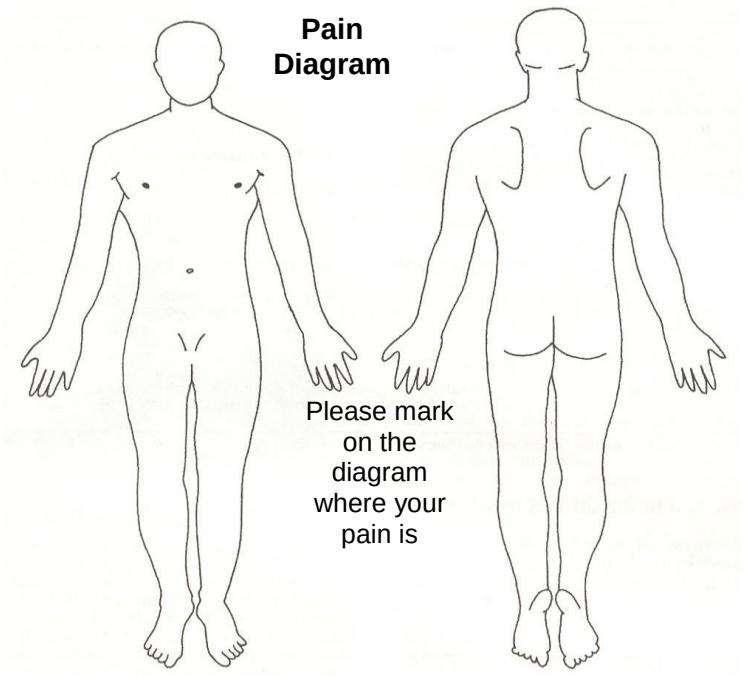
……
……
……

4. What do you think caused your problem?

……
……

5. Is the problem getting:

Worse ☐ Better ☐ No different ☐



6. Please rate the severity of any pain you have by ticking one of the boxes below:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain Unbearable pain

7. How would you describe the symptoms you are experiencing?

Sharp	☐	Stabbing	☐	Dull ache	☐	Burning	☐	Stiffness	☐	Tingling	☐
Pulling	☐	Pins&Needles	☐	Itching	☐	Nagging	☐	Throbbing	☐	Niggling	☐

8. Are there any other symptoms you are experiencing?

Referred pain ❑ Pins & Needles ❑ Numbness ❑ Burning ❑ Weakness ❑ **Where do you experience these symptoms?**

Left leg	☐	Left Arm	☐	Chest	☐	Groin	☐
Right Leg	☐	Right Arm	☐	Abdomen	☐	Hip	☐

9. What activities or movements make your condition worse?

……
……
……

10. What makes it feel better?

……
……

11. What daily activities are you finding difficult as a result of your condition?

Hobbies stopped	☐	Job (had time off)	☐	Sleeping reduced	☐	Every day activities	☐
Hobbies difficult	☐	Job (difficult to perform)	☐	Relationships	☐	House work	☐

Other (please describe) ……

12. Have you received a diagnosis or any treatment for your condition? Please give details.

……
……
……

13. Have you had any similar episodes before? Please give details.

……
……
……
……

14. Why have you come to see us? What would you like to achieve? Please tick.

- ☐ Diagnosis only, no chiropractic care
- ☐ Pain relief only
- ☐ Pain relief and correction of the underlying problem
- ☐ Pain relief, correction of underlying problem and preventative care
- ☐ Improvement of my over all health and wellbeing
- ☐ Other (please comment) .....

15. What is your occupation? If this has changed in the last 10 years, please state previous occupation as well.

Details:…….

16. What is your health aim? If you didn't have your condition what would you like to do?

……...
.....

17. Medical History. List any medical conditions you have, also any operations/investigations you've had with dates.

……
.....
.....
……

18 Do any illnesses run in your family eg: heart disease, stroke, cancer, diabetes? **Please list and state who is/was affected.**

……
.....
……

19. Accidents. Have you had any road traffic accidents, traumas or fractured any bones? Please give details.

……..
……..
……..

20. Medication. Please list any medication you are taking below (include any vitamin/mineral supplements).

……..
……..
……..
……..
……..

21. Do you smoke? Y/N…… **How many per day?** …… **Since what age?** ……

22. Do you drink alcohol? Y/N …. **Units per week?** ……... (1 unit = ½ pint beer/lager, 1 small glass of wine)

23. Do you exercise? Y/N…….. **What do you do?** …… **How often?** ……

24. Do you suffer from: Work stress…… **Physical stress**……. **Emotional stress**……...

25. Do you eat fresh veg: 1-3 x per week ❑ At least once daily ❑ Several times daily ❑ Never ❑

26. Do you eat fresh fruit: 1-3 x per week ❑ At least once daily ❑ Several times daily ❑ Never ❑

27. Do you drink water: 0-1 glass a day ❑ 2-4 glasses a day ❑ 4-6 glasses a day ❑ 6-8 glasses a day ❑

28. As well as your main complaint do you suffer with problems in any other areas? Please tick

Neck ❑	Upper Back ❑	Low Back ❑
Shoulder ❑	Elbow ❑	Wrist ❑
Hip ❑	Knee ❑	Ankle ❑
Headache ❑	Indigestion ❑	Irritable Bowel ❑

PATIENT REGISTRATION/CONSENT FORM

PATIENT DETAILS

Patient Name: _____ Date of birth: _____

Parent/guardian name (if patient under 16): _____

Address: _____

Postcode: _____ Home phone: _____

Mobile phone: _____ Email: _____

GP practice: _____ GP name (if known): _____

Occupation: _____ How did you hear about us: _____

CONSENT TO EXAMINATION

I consent to an appropriate physical examination.

Signed patient/guardian..... Date .....

CLINIC POLICY

We kindly request **24 hours notice for any cancellation or change of appointment**. Late changes or cancellations are subject to the standard appointment fee.

PRIVATE INSURANCE POLICIES

Patients who wish to claim the cost of their treatment on a health insurance policy must take the following action.

Before commencing your care you must have your insurer's approval. Please contact them and ask the following:

1. Does your policy allow you to claim for Chiropractic care?
2. Do you need a referral from your GP or Consultant prior to starting care?
3. Is there a financial limit or restriction on the number of visits you can have?
4. Is there an excess that you need to pay?

PLEASE NOTE:
Insurers may not reimburse for care given prior to the date you notify them or get approval for care. Please do not ask us to provide invoices that may compromise your claim.