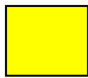


RETURNING PATIENT CONSULTATION FORM

BACK-IN-ACTION CHIROPRACTIC CLINIC

Pain Relief, Rehabilitation, Prevention and Well-being

28 Cop Lane,
Penwortham,
PRESTON, PR1 0SR
Tel: 01772 749389

First Name/s:		Surname:	Title:	Date:
Address:			Post Code:	
Phone:	Home	Mobile	Work	
E-mail:			Age:	DOB:
I consent for my e-mail to be used for follow up information about my care, appointment reminders, and receiving the clinic newsletter.		**Yes / No** (Please delete or circle yes/no)	**Signed:**	

Height:	Weight:	Marital Status: S M P D S W	Children? Ages:

How did you find out about us?	Friend	Family	Colleague	GP	Advert	YP	Internet	Other

We usually contact your GP. Do you give your consent?	**Yes / No** (Please delete or circle yes/no)	**Signed:**
GP Name:	Address:	
Telephone:		
Do you consent to an appropriate physical examination?	**Yes / No** (Please delete or circle yes/no)	**Signed:**

ALL INFORMATION IS KEPT IN THE STRICTEST CONFIDENCE. We appreciate this form is a bit of a marathon!!

All information could be relevant to your condition. Please fill out the questionnaire as completely as possible. Just do your best!

How is your problem affecting your life?

What outcome are you hoping to expect from chiropractic treatment?

Why is that outcome important to you?

What are your main complaints: please number in order of severity

Headache	Neck	Upper back	Lower Back	Arm (R or L)	Leg (R or L)

Other:

When did this episode begin? | How long do the symptoms last?

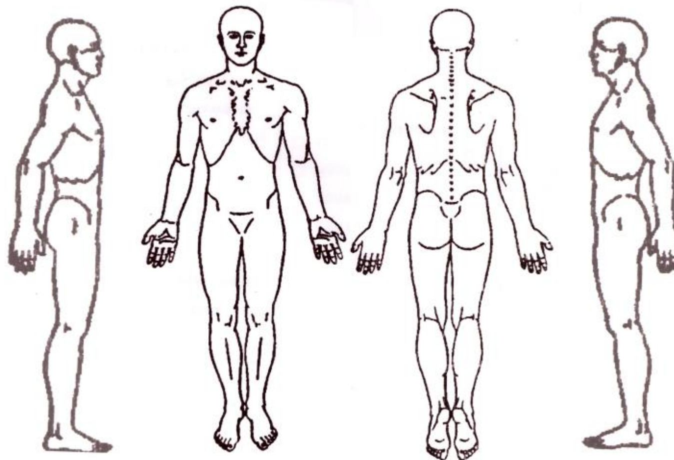
How often do symptoms occur? | Is it getting: better, worse, same, comes and goes?

Have your suffered from this complaint before? YES/ NO | How long for? | How many episodes?

How long does it usually last for? | How long is it since you last felt really well in yourself?

Please label painful or problem areas on the diagram

CP = Constant Pain
P = Pain
A = Aching
D = Dull Aching
NA = Nagging
ST = Stabbing
SH = Shooting
TI = Tingling
NU = Numbness
TE = Tension
SF = Stiffness
S = Swelling
B = Burning
TH = Throbbing
W = Weakness
WA= Wasted Muscle
X = Scars
* = Body Piercing



Are you experiencing any pain you would describe as any of the following: Sickening, Squeezing, Exhausting or Electric

Is your pain increased by any of the following? Coughing Sneezing Straining Bowel Movements

Was there any illness, trauma, or significant event prior to or during the onset, that may have caused the problem:

Illness, Stress, Fall, Lifting, Sitting, Bending, Strain, Posture, Accident, Gardening, DIY, Sports, Work, No Apparent Cause, Other:

What is your condition stopping you doing? Lifting, Sitting, Bending, Standing, Walking, Climbing stairs, Running, Resting in bed, Intercourse, Data entry/typing, Work activity, Household activity, Recreational activity, Other:

What makes it feel worse?

What makes it feel better?

When is it at its worst? (Time of day or type of activity?)

Can you control this condition by changing your body position? YES/NO How?

Which of the following best describes your current condition?	
There is still pain at rest.	YES/ NO
I have no pain at rest but continue to find normal activity painful.	YES/ NO
I am able to perform all normal unstressed basic activities of daily living comfortably.	YES/ NO
I can perform all normal activities of daily living with minimal constraints.	YES/ NO
I feel able to perform full unconstrained activity in comfort.	YES/ NO

How uncomfortable in general are you on a scale of 1 to 10? (1/10 is really comfortable and 10/10 is the worst pain possible)

At its worst?	At its best?	Usually?

Put a CROSS in ONE box 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
No pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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'?

	0	1	2	3	4	5	6	7	8	9	10
No interference	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
Not at all anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
Not at all depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 'makes it no worse' and '10' is 'makes it very much worse'?

	0	1	2	3	4	5	6	7	8	9	10
Makes it no worse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
I have complete control over my pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have night sweats?	YES./NO	Does the pain awaken you at night?	YES/NO
Do you sleep well?	YES/NO	Any recent malaise or fever?	YES/NO
Any weight loss or gain?	YES/NO	Any blood in your urine, stools or sputum?	YES/NO
Any loss of consciousness?	YES/NO	Any personality changes or confusion?	YES/NO
Any double vision?	YES/NO	Have you had unusual headaches recently?	YES/NO
Have you had any recent dizziness or vertigo?	YES/NO	Any loss of or altered sensation wiping your bottom?	YES/NO
Have you ever been diagnosed with cancer?	YES/NO	Unusual problems with your bowel or bladder?	YES/NO
Regular breast, smear or prostate checks?	YES/NO	Any changes or loss of feeling with sexual function?	YES/NO
Are you involved in any legal proceedings?	YES/NO	Are you happy at work?	YES/NO
Is the pain you are in harming you?	YES/NO	Do you believe the pain you are in may disable you?	YES/NO
Are you avoiding certain activities/ situations?	YES/NO	Are you tending to rest or keep active?	Rest/Keep Active
Are you withdrawing from social interactions?	YES/NO	Is treatment the only thing that can help you?	YES/NO
Do you believe you can get fully better?	YES/NO	Any emergency admissions to hospital with this?	YES/NO

Which Medical or Complementary Practitioners have you seen about this or other conditions (use separate sheet if required)**:**

Date	Name	Address	Diagnosis	Treatment	Result

Have you ever had any X-rays, Blood, Urine, CT, MRI**,** or other medical tests? **(Please circle) What was the result?**

Regarding your past general health. Please describe:

Accidents? Road traffic, concussions	Injuries? Falls, sprains, fractures
Operations?	Hospitalised?
	Recent medical treatment?
Serious Illness?	Any other health problems?
Medicines? (Please use separate sheet if required)	Allergies?
	Supplements?

Conditions suffered by your blood-related family?

Blood pressure, Heart disease, Cancer, Diabetes, Stroke, Arthritis, MS, Neurological disorders, Parkinson's, Alzheimer's, Mental health, Joint/muscle pain, Genetic diseases, Others:

Regarding your social history:

Tobacco YES NO EX	How many per day?	How long for?	Alcohol units per week:	
How many cups a day?	Tea	Coffee	Water	Fizzy Drinks

Hobbies/Sports:	Special Diet?: low fat, vegetarian, vegan, low calorie, low sugar, low salt, low carb, food allergy restricted, other:

Any emotional stress?	Relationship	Career	Children	Money	Family Sickness	Bereavement

Your Occupation Now?	How many years?	Previous Occupation?

Does your job involve?	Bending	Lifting	Driving	Sitting	Standing	Stress

Hours per week:		Are you exposed to any hazardous materials? Yes/ No

PTO

Are There Any Other Areas Of Your Health With Which You Might Appreciate Some Help?

By now most of the symptoms of the problem you originally consulted with are much improved. Is there anything else we can do to help? Perhaps you have other health issues you would like to improve which might benefit from a natural holistic health approach?

We can help you optimize your health by suggesting ways for you to reduce the stress caused by deficiencies and toxicities, that is by helping you increase your "purity and sufficiency". The holistic approach applied by the practitioners at ***Back-in-Action*** is based on helping you to improve wellbeing in the following areas:

- Physical:
  - Movement of the joints and muscles and affects these have on the nervous system.
  - Helping you look after the bodies physical exercise needs.
- Nervous system:
  - Helping you improve your mental and emotional responses and experience.
  - Optimizing the activity of the nervous system
- Chemical:
  - Helping you get the right building blocks to assist you improving your health.
  - Reducing environmental stressors.

Some of the areas we might be able to help you with are listed below. Please add any other areas of concern:

Do You Have Any Symptoms?	**Very Bad**	**Poor**	**Average**	**Good**	**Excellent**
Digestive Problems:					
Allergies:					
Breathing Issues:					
Coughs and Colds:					
Stress:					
Anxiety:					
Depression:					
Emotional Problems:					
Difficulty sleeping:					
Fatigue:					
Infections:					
Skin Conditions:					
Hair Loss or Gain (females):					
PMS:					
Bladder Condition:					
Sexual Function:					
Blood Pressure:					
Emotional Problems:					
Other: (please list)					

Data Protection / Privacy Policy: By requirement of The Chiropractors Act (1994) and the General Data Protection Regulations (GDPR), this clinic is required to maintain and retain a complete record of consultations and treatments. This information is confidential and only released to third parties with a patient's express and

written permission. Confidential patient information is only accessible to staff at this clinic with a direct and appropriate need to do so. All material is kept whilst the individual remains a patient of the clinic and, thereafter for a period of eight years, after which it will be securely destroyed. In accordance with the Data Protection Act (1988) a patient may request a copy of their patient record at any time and expect this to be supplied within a reasonable time frame. In accordance with the law, a commensurate charge maybe levied. We will never pass your personal contact information to third parties without prior notice and consent save for the rare circumstance when your data is requested by a government agency in relation to for example, a crime or for reasons of national security. This clinic may contact you from time to time, using contact information provided, to let you know about matters relating to the clinic. You may choose not to receive this information at any time by letting us know.

I have read and understand the Data Protection / Privacy Policy and Give My Consent

Date: **Signature**:

I confirm my ongoing consent to Chiropractic treatment

Date: **Signature:**

The content of this form is accurate to the best of my knowledge

Date : **Signature**:

Do you give your consent to receiving Marketing Communications?	**Yes / No** **(Please delete or circle yes/no)**	**Signature:**

Thanks for your time. Please feel free to discuss your progress and any other health issues with which you might want to try and help through natural medicine with your doctor of chiropractic at your earliest convenience, so we can begin to help to further improve your health, in which ever way we can.