ANNUAL REVIEW
Are We Aware Of Where You Are Up To?

BACK-IN-ACTION **CHIROPRACTIC CLINIC**

Pain Relief, Rehabilitation, Prevention and Well-being

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First Name:	Surname:	Title:	Date:
Address:		Post Code:	
E-mail:		Age:	DOB:

ALL INFORMATION IS KEPT IN THE STRICTEST CONFIDENCE

How has your care at *Back-in-Action* helped up to now?

What activities can you now do again?

How comfortable is this condition presently on a scale of 1 to 10? (1 is the worst and 10 is the best you've ever felt)

At its worst? At its best? Normally?

Do you have any remaining physical complaints?

Headache	Neck	Upper back	Lower Back	Arm (R or L)	Leg (R or L)
Other:		Secondary complaints:			

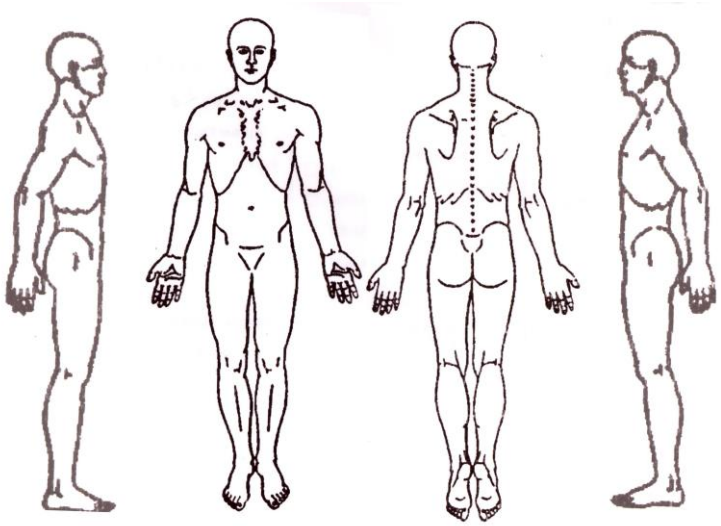
Is it getting better, worse, same, comes and goes? How long does it usually last for?

What outcome would you like to achieve with these complaints?

Why is this important?

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
X = Scars
* = Body Piercing



Would you describe your pain as any of the following: Sickening Squeezing Exhausting

Is there anything that you believe may be continuing to aggravate this condition:

Fall, Lifting, Sitting, Driving, Bending, Strain, Posture, Accident, Gardening, DIY, Sports, Work, Medications, Health Conditions, Diet, Lack of exercise, Stress, Other:

Which of the activities listed below are you now able to do comfortably?

Lifting, Sitting, Bending, Standing, Walking, Climbing Stairs, Running, Resting in bed, Intercourse, Data entry/ typing, Gardening, Work activity, Household activity, Recreational activity, Extreme activity, Gym, Sports, Other:

What makes it feel better?

What makes it feel worse?

When is it the pain at its worst?

Morning, Afternoon, Evening, Night, Constant, Normal Activity, Strenuous Activity, Other:

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

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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

Have you consulted any Medical or Complementary Practitioners about any recent or past conditions

Date	Name	Address	Diagnosis	Treatment	Result

Have there been any other changes in your health medically?	
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 or double vision? YES/NO	Any personality changes or confusion? YES/NO
Have you had any recent dizziness or vertigo? YES/NO	Have you had unusual headaches recently? YES/NO
Have you at ay time been diagnosed with having cancer? YES/NO	
Do you have regular NHS check-ups of the breasts, cervical smear or prostate? YES/NO	

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?	Hospitalisations?
Serious Illness?	Recent medical Treatment?
Medicines?	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:		

On a scale of <u>Poor, Good, Excellent</u> describe your:			
Diet	Exercise	Sleep	General Health

Any emotional stress? How are you happiness levels?					
Relationship	Career	Children	Money	Family Sickness	Bereavement

Your Occupation?	How many years?	Previous Occupation?

What does your job involve?	Bending	Lifting	Driving	Sitting	Standing	
Hours per week:		Are you exposed to any hazardous materials? Yes/ No				

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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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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)					

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Informed Consent to Chiropractic Adjustments and Care at Back-in-Action

Before we can start your treatment programme, we need to gain your consent for any procedures we apply.

I have revealed details on all my past health issues, medical conditions, medications and any history of substance abuse.	**Initial:**

I consent to an appropriate physical examination.	**Initial:**

I will refrain from the use of recreational drugs or alcohol prior to treatment.	**Yes / No**	**Initial:**

Practitioners using manual therapy techniques, such as adjustment, manipulation or mobilisation, are required to inform patients that there are or maybe some rare risks associated with such treatment. Please read your '**Information for Consent to Chiropractic Care**' carefully before your Returning Patient consultation. If you are satisfied please sign. If you want to, you can discuss any issues with your physician before signing.

I have read the 'Information for Consent', I am aware of the potential risks associated with chiropractic treatment.	**Initial:**

I have had an opportunity, if I wished, to discuss the nature and purpose of chiropractic adjustments and other procedures in general and my treatment in particular as well as the contents of this consent.	**Yes / No**	**Initial:**

I confirm that I have received and understood the information given to me regarding my case, the proposed treatment and its implications. I understand that results are not guaranteed and that my Chiropractor has many years of training in diagnosis and treatment. Whilst I understand my Chiropractor has attempted to give me a complete and accurate description of my complaint and possible risks I do not expect my Chiropractor to anticipate and explain all the risks and complications of treatment and I wish to rely on my Chiropractor to exercise best judgement during the course of the procedure which my Chiropractor feels at the time, based on the facts then known, is in my best interest.

Initial:

I hereby request and consent to chiropractic adjustments and other therapies performed on me by my Chiropractor to the joints, ligaments, muscles, fascia, nerves and other soft tissues.

I give my Informed Consent to treatment and understand that at any time I may withdraw my Consent and treatment will be stopped.	**Signed:**

From time to time we collect information to prepare an anonymized statistical report for research purposes. I give my consent for my information to be used in these statistical reports.	**Yes / No**	**Signed:**

We may on occasion contact your GP, to let them know what we have found and offer recommendations. Do you give your consent?	**Yes / No**	**Signed:**

I consent for my e-mail address to be used for follow up information about my care and appointment reminders.	**Yes / No / NA**	**Signed:**

I consent for my postal address to be used for follow up information about my care and appointment reminders.	**Yes / No**	**Signed:**

I consent for my mobile number to be used for follow up information about my care and appointment reminders.	**Yes / No / NA**	**Signed:**

I consent to receiving the Clinic Newsletter and Promotions.	**Yes / No**	**Signed:**

Privacy Policy Summary

Data Protection Act 2018 (GDPR) – Your Personal Information is to be:

1) Processed lawfully, fairly and in a transparent manner
2) Collected for specific, explicit and legitimate purposes
3) Adequate, relevant and limited to what is necessary
4) Accurate and where necessary, kept up to date, with inaccuracies being erased or rectified without delay
5) Kept in a form that permits identification of you for no longer than is necessary for the purposes for which your Personal Data is processed
6) Processed in a manner that ensures appropriate security of your Personal Data including protection against unauthorized or unlawful processing and against accidental loss, destruction or damage.

Most Registration Forms are stored in the Clinic and the information on the forms and that of those who have requested Articles and / or Newsletters via the Website is entered in the Clinic Software.

The Clinic Software is backed up securely by our Data Processor Software Supplier to third–party Hosting Companies.

We also keep a list of first names and email addresses of patients and those who have requested Articles and / or Newsletters securely on our Website which is managed by another of our Data Processors.

Personal records are only released to third parties if authorized by you in writing or if required by a government agency.

You may choose at any time to have your Email Address Unsubscribed and / or to stop receiving mail or texts by notifying us by email or in writing.

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I have read and understand the Summary of the Data Protection / Privacy Policy and consent to my personal data being held by Back-in Action. I am aware I can ask for a paper copy of the full Data Protection / Privacy Policy at any time or see it on the Back-in-Action website.	**Signed:**

The content of this form is accurate to the best of my knowledge.	**Signed:** **Date:**

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.