RETURNING PATIENT REGISTRATION FORM

BACK-IN-ACTION CHIROPRACTIC CLINIC

Pain Relief, Rehabilitation, Prevention and Well-being

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PRESTON, PR1 0SR
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First Name/s:	Surname:	Title:	Date:
Address:		Post Code:	
Phone: Home	Work	Mobile	
E-mail:			

Height:	Weight:	Marital Status: S M P D S W	Children? Ages:
Age:	DOB:	Your current occupation?	

How did you find us?	Friend	Family	GP	Web	Facebook	YP	Advert	Other

GP Name:	Tel.:	Address:

All information is kept in the strictest confidence. This form is a marathon! However it will help us to help you. Try your best!

How is your problem affecting your life?

What outcome do you want from chiropractic treatment?

Why is this important to you?

How will you know when things have improved?

Why did you choose care with us?

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

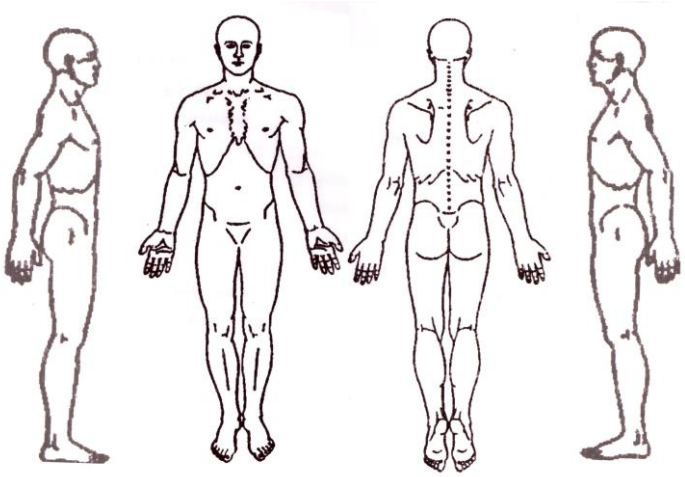
Headache	Neck	Upper back	Lower Back	Arm (R or L)	Leg (R or L)

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 <u>uncomfortable</u> 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 'make it no worse' and '10 is 'make it very much worse'?

	0	1	2	3	4	5	6	7	8	9	10
Make 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?	Hospitalisations ?
	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				

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Are There Any Other Areas Of Your Health With Which You Have Problems?

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:					
Bowel Problems:					
Blood Pressure:					
Other: (please list)					

Data Protection / Privacy Policy Summary

General Data Protection Regulation (GDPR) – 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 Data Subjects for no longer than is necessary for the purposes for which Personal Data is processed
6) Processed in a manner that ensures appropriate security of the 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 kept for the period required by law and 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 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.	**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 to an appropriate physical examination.	**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 to receiving the Clinic Newsletter and Promotions.	**Yes / No**	**Signed:**
I consent to receive treatment.	**Yes / No**	**Signed:**
The content of this form is accurate to the best of my knowledge.	**Yes / No**	**Signed:** **Date:**