NEW PATIENT REGISTRATION FORM

***BACK-IN-ACTION* CHIROPRACTIC CLINIC**

Pain Relief, Rehabilitation, Prevention and Well-being

28 Cop Lane, Penwortham,
PRESTON, PR1 0SR
Tel: (01772) 749389
reception@back-in-action.com

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:			Surgery:					
GP Phone:			Address:					
Name Next Of Kin:						Phone:		

This form is a marathon! However it helps us to help you. Do your best! All your information is confidential.

How is your problem affecting your life?

What are you most struggling with that you really need to be doing?

What worries and concerns do you have about your problem?

What do you believe is causing your problem?

What outcome do you want from chiropractic treatment?

Why is this outcome important to you?

What do you want to be able to do or enjoy more when you are better, that you can't do now?

Why is that important for you? What do you live for most?

What are you expecting us to do to help you?

What are you expecting from your 1st visit?

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

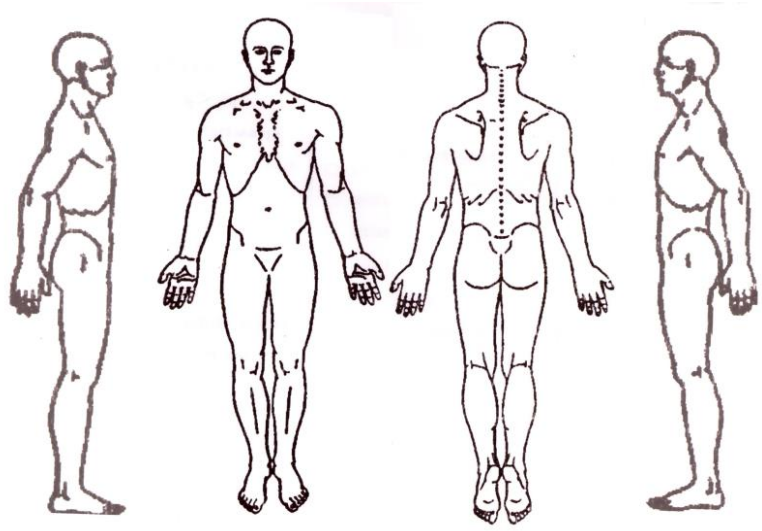
Headache	Neck	Upper back	Lower Back	Arm (R or L)	Leg (R or L)

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 many episodes of pain in the last year have you had?	
Have you had more than 30 days pain in the last 12 months?	YES/ NO
How long is it since you last felt really well in yourself?	

Please label painful or problem areas on the diagram

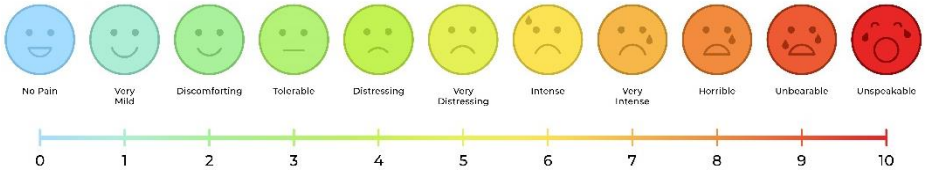
CP = Constant Pain
P = Pain
A = Aching
D = Dull Aching
NA = Nagging
ST = Stabbing
SH = Shooting
Ti = Tingling
NU = Numbness
Te = Tension
SF = Stiffness
S = Swelling
B = Burning
TH = Throbbing
W = Weakness
Wa= Wasted Muscle
X = Scars
* = Body Piercing



How uncomfortable in general are you on a scale of 0 to 10? (0 is no pain and 10 the worst pain possible)

Please label:

At its worst: **-**
Usual/ average: **x**
At its best: **+**



Are you experiencing any pain you would describe as: 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 around 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, Travelling, Other:

What makes it feel worse?

What makes it feel better?

What have you tried that hasn't made it worse or 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 do you rate your chance of recovery? Slight Moderate Good Excellent Full

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 unable 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Over the past few days, on average, how has your **sleep** been affected, on a scale where '0' is 'not at all affected' and '10' is 'completely unable to sleep'?

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

Over the past few days, how has your ability to **travel** been affected, on a scale where '0' is 'not at all affected' and '10' is 'not able to travel at all'?

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

Over the past few days, how do you think your **recreational** activities (both inside the home and outside) 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
Is your ability to return to work affected?	YES/NO	Is your pain uncontrollable?	YES/NO
Is your work likely to cause you further injury?	YES/NO	Are you supported by colleagues and supervisors?	YES/NO
Can you modify your work duties?	YES/NO	Anything restricting or affecting your return to work?	YES/NO

Which Consultants, Surgeons, Physios or Other Practitioners have you seen about this or other conditions (use separate sheet**)**

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?
	Any mental health issues?
Medicines? (Please use separate sheet if required)	Allergies?
	Supplements?

Where are you this health range? (Please tick) **Where do you want to be on this health range?** (Please circle)

"I am fully alive. A 100% expression of health."	"I am very athletic but I can overdo it sometimes."	"I'm fit and slim but I work really hard."	"I enjoy being active but I need to get more done."	"My life is okay, could be better, could be worse."	"I'm too busy to look after myself as well as I should."	"Health isn't a high value. I know I should but it's hard."	"Poor health. I'm just struggling to do the basics."

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?	Hours per week?		How many years?		Previous Occupation?	
Does your job involve?	Hazardous materials	Bending	Lifting	Driving	Sitting	Standing	Stress

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 (i.e. not intoxicated in excess of the Legal Limit for driving).	**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 (Patient Copy)**' carefully before your first 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 to Chiropractic Care (Patient Copy)', 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.

Signed:

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:** **Date:**

Permissions For Us To Make Use Of Your Data

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

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**

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

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

PTO

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

I consent to receiving the Clinic Newsletter.	**Yes / No**

I consent to receiving the Clinic Promotions.	**Yes / No**

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.

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. I understand I can notify Back-in-Action if I want to change my permissions for the clinic to contact me.	**Signed:** **Date:**