UP & ABOUT

Western Medical Acupuncture
Family Chiropractic
Sports Injuries
& Massage

Patient Questionnaire

Date…………………

Mr/Mrs/Ms/Miss *(please circle)*

Surname……………………………………. Age……..……………………………...

Forenames…………………………………. Date of birth…….…………………......

Address………………………….................

………………………………………………. Home Tel……………………………….

………………………………………………. Work Tel………………………………..

Postcode……………………………………. Mobile…………………………………...

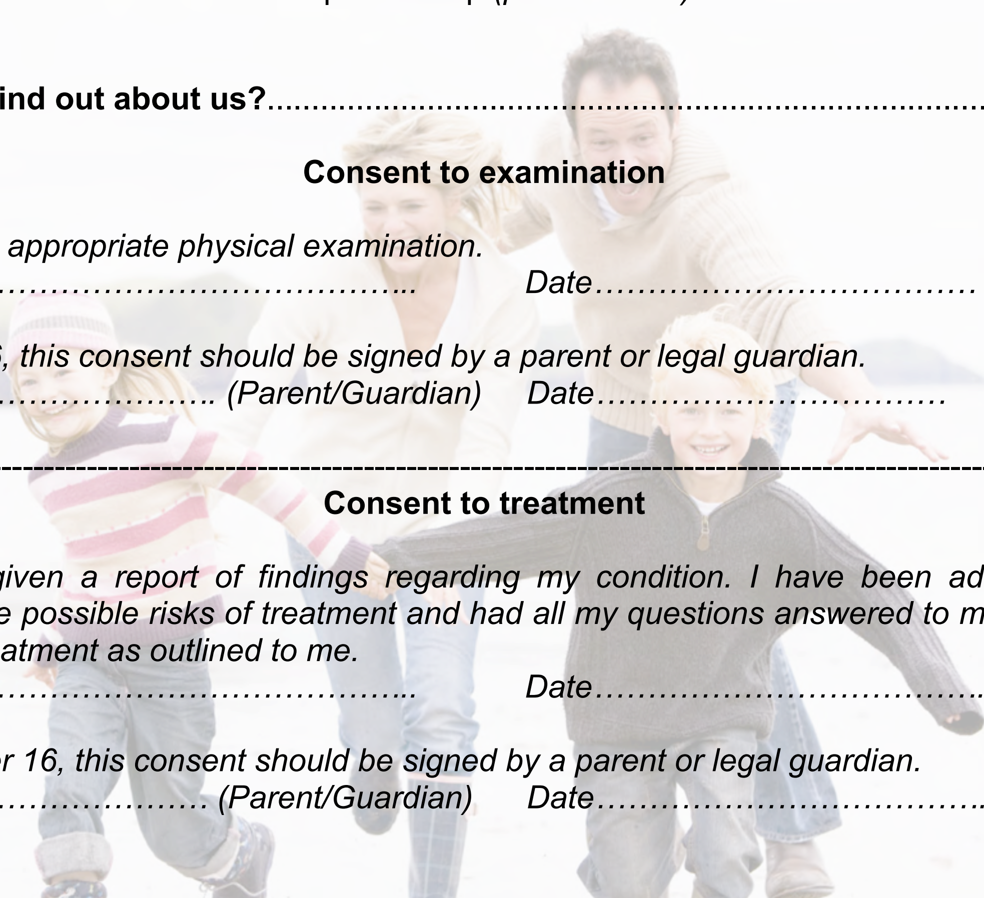
Email address………………………………………………………………………………...

Occupation…………………………………. Number of children………………………

Previous occupation………………………. Ages and sex…………………….........

Married/single/divorced/widowed/civil partnership *(please circle)*

How did you find out about us?...



Consent to examination

I consent to an appropriate physical examination.
Signed…………………………………………... *Date………………………………*

If you under 16, this consent should be signed by a parent or legal guardian.
Signed…………………………. (Parent/Guardian) *Date……………………………*

Consent to treatment

I have been given a report of findings regarding my condition. I have been advised of, and understood, the possible risks of treatment and had all my questions answered to my satisfaction. I consent to treatment as outlined to me.
Signed…………………………………………... *Date……………………………….*

If you are under 16, this consent should be signed by a parent or legal guardian.
Signed………………………… (Parent/Guardian) *Date………………………………...*

Where are your problems? *(please also mark the diagram)*

Neck □ Shoulder □ Arm □ Elbow □ Wrist □ Hand □ Finger □

Mid-Back □ Low-Back □ Buttock □ Hip □ Upper-leg □ Knee □

Calf □ Ankle □ Foot □ Toe □ (please describe below)……………..…………………….

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

Do you have any of the following symptoms?

Numbness □ Tingling □ Burning □ Pins & Needles □ Cold/Hot □ Headaches □

Dizziness □ Weakness □ (please describe below)……………………………………….......

……………………………………………………………………………………………………..

How would you describe the pain?

Sharp □ Shooting □ Dull ache □ Burning □ Mixed □

Other □ (please specify)…………………………………………………………………...

How severe is the pain? *(0-10 scale, 0 = no pain, 10 = severe pain)*…………………….…..../10

When did it first start?…………………………………………..

What do you think caused it?………………………………………..

……………………………………………………………………………………………………..

Is it getting worse / staying the same / getting better? *(please circle)*

Does anything make it better?……………………………………………………………...........

What seems to make it worse?……………………………………………………………….....

Is it worse in the morning or at the end of the day?……………………………………………

Does it wake you at night? Y/N

Have you had this before? Y/N If yes, how often?…………………………………….............

Is this the worst episode? Y/N

What treatment have you had for this problem so far? *(Pain killers, GP, Physio, Osteo, Chiro)*

……………………………………………………………………………………………………...

Have you had any headaches, neck or back problems before? *(please specify)*…………………..

……………………………………………………………………………………………………..

Please list *any* accidents or falls you have had………………………………………..............

……………………………………………………………………………………………………..

……………………………………………………….. (*include car accidents, sports injuries, falls etc*)

Have any members of you family (mother, father, grandparents, brother or sisters) suffered from any of the following conditions?

Diabetes □ Heart attack □ Stroke/TIA □ Arthritis □ Cancer □ Auto-immune □

Thyroid □ Epilepsy □ Nervous system □ Gastro-intestinal □

(please specify)……………………………………………………………………….............

…………………………………………………………………………………………….........

Do you suffer from any of the following problems?

Eye problems □	*Fainting* □	*Tremors* □
Double vision □	*Nausea/vomiting* □	*Inco-ordination* □
Dental problems □	*Loss of appetite* □	*Night sweats* □
Jaw pain □	*Abdominal pain* □	*Mood swings* □
Speech problems □	*Incontinence* □	*Sleep disturbances* □
Swallowing difficulties □	*Difficulty urinating* □	*Nervousness/anxiety* □
Ringing ears □	*Blood in urine* □	*Depression* □
Deafness □	*Bladder or bowel problems* □	*Muscle cramps* □
Skin problems □	*Rectal bleeding* □	*Muscle pain* □
Chest pain □	*Constipation* □	*Joint pain* □
Productive cough □	*Pain in reproductive organs* □	
Difficulty breathing □	*Headaches* □	
Wheezing □	*Dizziness* □	

Please list all serious illnesses *(previous and current)*………………………………………………

………..

Have you ever been hospitalised and for what?……………………………………………….............

Have you ever had an x-ray? Y/N If yes, When?……………………………………………………….

Have you ever broken any bones? Y/N If yes, when?……………………………………………….

Have you had any of the following tests: Urine / Blood / CT Scan / MRI / Bone Scan *(please circle)* Why?...

Date of last GP visit………………………Reason for visit?..

Last menstrual period…………………………………………………………………………….....

Last cervical smear…………………………………………………………………………………...

Last breast exam……………………………………………………………………………………...

Last prostate exam……………………………………………………………………………………

Height………..…Weight……..……Have you lost / gained weight recently? *(please circle)*

Do you smoke or have you ever smoked? Y/N If yes, how many per day?...............................

Do you drink alcohol? Y/N If yes, how many units per week?...

Do you use any recreational drugs?...

………..

Please list any current medications, vitamin or mineral supplements you take……………………..

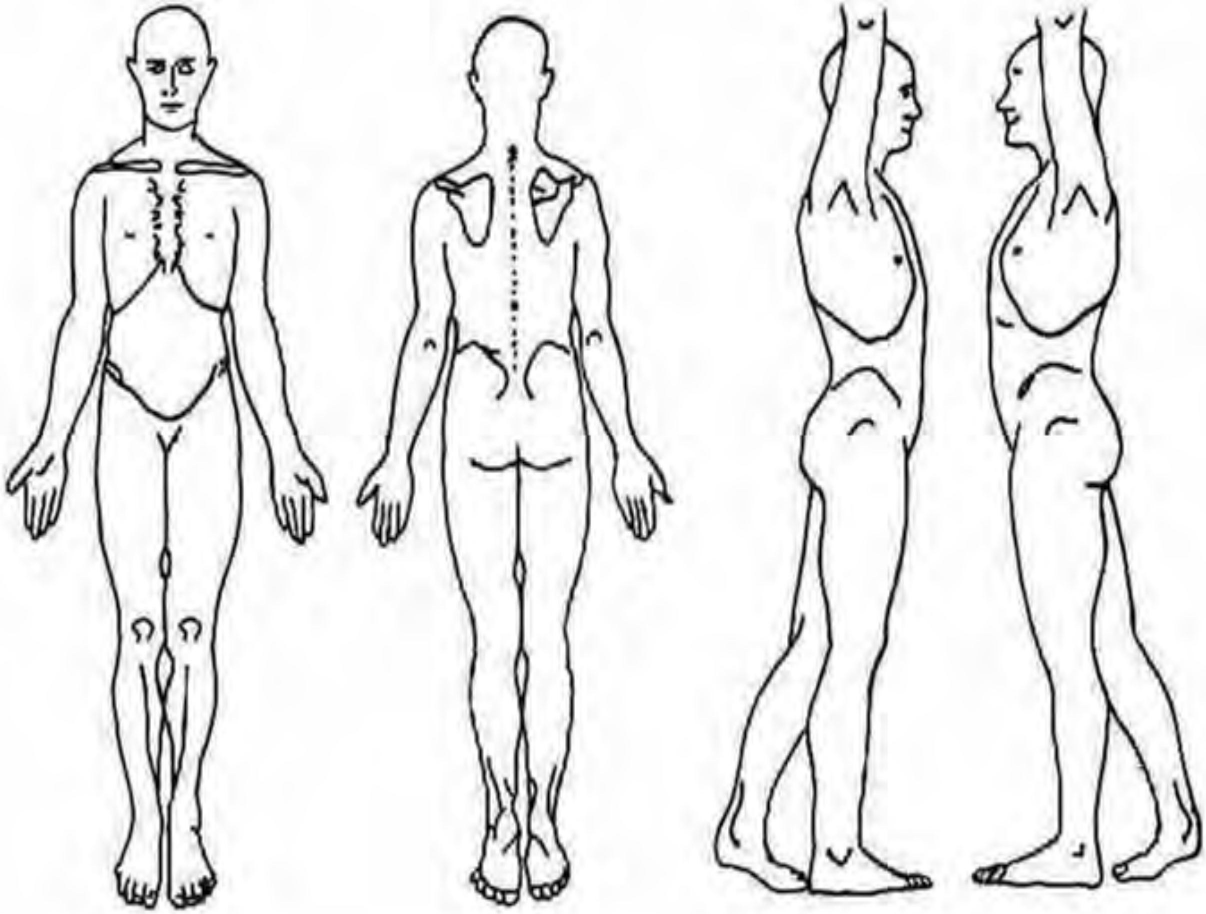
………..

………

Do you consider yourself in optimal / average / poor health? *(please circle)*

What are your hobbies/interests/sports?...

Patient Symptom Diagram



Please mark on the diagram all areas of your body where you feel the described sensations using the appropriate symbol. Include all affected areas.

Numbness	= = =
Burning	xxx
Pins and needles	ooo
Stabbing	//////
Aching	zzz

Any other symptoms please mark on with your own symbol and note the symbol below.