NEW PATIENT ENTRANCE FORM

HOPE SPINAL WELLNESS

WELCOME

We are a family practice transforming the health of the community through chiropractic and lifestyle adjustments. For us to properly understand your health problem we need information about your present conerns. We also need information about your general health.

Please answer every question to the best of your ability.

Thank you for your co-operation in completing this New Patient entrance form.

PERSONAL DETAILS

TITLE: (Please Circle) Mr / Mrs / Miss / Ms / Mst / Dr

NAME: .....

ADDRESS: .....

POSTCODE: ..... PHONE: (H) ..... (M) ....

E-MAIL ADDRESS: ..... MARITAL STATUS: S M W D Sep

DATE OF BIRTH: ..... AGE: .... MALE ❑ FEMALE ❑

OCCUPATION: ..... EMPLOYER: .....

SPOUSE'S NAME: ..... NO. OF CHILDREN: .....

Who or what referred you to this clinic? .....

PREVIOUS AND CURRENT HEALTH

I WOULD LIKE HELP FOR: .....

.....

.....

OTHER PROBLEMS I AM CONCERNED WITH: .....

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.....

CAR ACCIDENT(S) WHEN? INJURIES? .....

.....

.....

OTHER PERSONAL INJURIES/ACCIDENT(S) WHEN? INJURIES? .....

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EXERCISE PROGRAMS/SPORTING ACTIVITIES? .....

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SUPPORTS - BACK/FOOT? .....

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OPERATIONS? .....

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DRUGS/MEDICINES/VITAMINS - TYPE/DOSAGE, etc? .....

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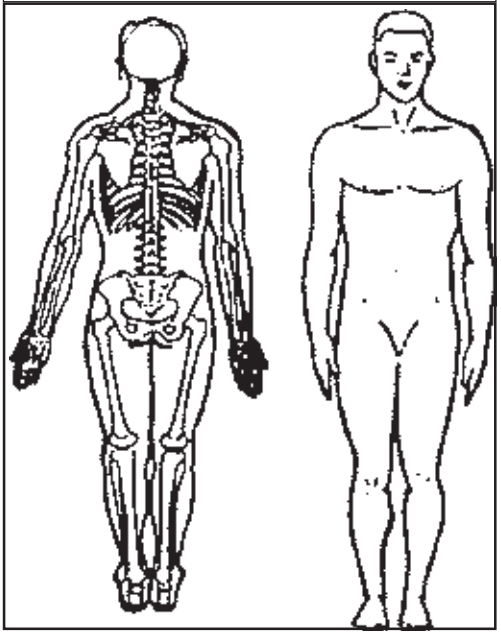
PLEASE MARK AFFECTED AREAS



IF YOU HAVE EVER HAD SPINAL CARE BEFORE, PLEASE COMPLETE THE FOLLOWING

Name of Practitioner ..... Located Where? .....

What were you being treated for? .....

IN DEPTH SYMPTOM SURVEY

Would you please tick (✔) any of the following symptoms or problems as they apply to you.
Those conditions which you have never had please leave blank

GENERAL SYMPTOMS

- ❑ Headaches
- ❑ Vertigo
- ❑ Allergies
- ❑ Sinus Trouble
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Sensation
- ❑ Excessive fatigue
- ❑ Fevers
- ❑ Sudden loss of weight
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Depression
- ❑ Sweating excessively
- ❑ Tremors
- ❑ Poor circulation
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Constipation
- ❑ Diarrhoea
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Difficulty starting urine
- ❑ Difficulty controlling urine
- ❑ Bed wetting
- ❑ Kidney infection
- ❑ Bladder infection
- ❑ Pain in chest
- ❑ Pain arround ribs
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Tightness around chest
- ❑ Rapid heart beat
- ❑ Other .....

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MUSCLE AND JOINT

- ❑ Low back pain
- ❑ Neck pain or stiffness
- ❑ Poor posture
- ❑ Sciatica
- ❑ Arthritis
- ❑ Bursitis
- ❑ Foot trouble
- ❑ Hernia
- ❑ Pain between shoulders

Pain or numbness in:

- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

- ❑ Painful tail bone
- ❑ Spinal curvature
- ❑ Swollen joints

FEMALES ONLY

Are you pregnant?
Yes ❑ No ❑

- ❑ Painful or tender breast
- ❑ Lumps in breast
- ❑ Period pains
- ❑ Excessive menstrual flow
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ Hot flushes
- ❑ Menopausal symptoms
- ❑ Endometriosis
- ❑ Other .....

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HAVE YOU EVER HAD ANY OF THESE DISEASES OR DISORDERS

- ❑ Appendicitis
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Tuberculosis
- ❑ Gout
- ❑ Heart Disease
- ❑ Goitre
- ❑ Malaria
- ❑ Pleurisy
- ❑ Alcoholism
- ❑ T.I.A.
- ❑ Anaemia
- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Cancer
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Immune Deficiency
- ❑ Ulcers
- ❑ Eczema
- ❑ Stroke

FOR MEN ONLY

- ❑ Prostate trouble
- ❑ Impotency
- ❑ Other .....

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- If X-rays are required, please understand that the fee charged is for taking, developing and reading the films. They remain part of you permanent case files at Hope Spinal Wellness.
- Fee for new patient consultation and examination is £60. If X-rays are required the fee is an additional £80.
- I understand that no accounts are rendered by this centre and my payment at the time of first treatment will be:

❑ CASH ❑ CHEQUE

• I HEREBY GIVE CONSENT TO UNDERGO A NEW PATIENT CONSULTATION AND/OR EXAMINATION

SIGNATURE: ..... DATE: .....