FOR OFFICE USE Pt No _____

Examination consent signed Y N
Informed consent form signed Y N
GDPR Completed Y N
Reminder set up Y N
GP letter sent Y N

Insurance Company _____
Insurance Number _____

newland
Chiropractic & Neurology Centre

New Patient Form

Please fill in your details below

Title _____ Surname _____ Forename(s) _____

Address _____

_____ Postcode _____

Phone (H) _____ (W) _____ (M) _____

E-mail _____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____ Marital Status _____ No. Of children _____

GP Name _____ Surgery _____

How did you hear about our clinic? Tick appropriate box

- ☐ Family member or friend. Who may we thank for recommending us? _____
- ☐ Website
- ☐ Recommendation by GP or other healthcare professional, who? _____
- ☐ Voucher / Special Offer, which one? _____
- ☐ Advert or Article, which publication? _____
- ☐ Other, please give details _____

Appointment Reminder Service

A reminder will be sent to you **TWO DAYS** before any future appointment via text or E-mail to the contact details above.

To ensure that more appointments are available to patients, **all missed appointments and late cancellations (less than 24 hours notice)** will be charged at the **full treatment rate.**

Would you like us to send you a reminder? Please tick appropriate box:

- ☐ Text
- ☐ E mail
- ☐ Please do not send me a reminder, I will remember

Please turn over

The following scales have been designed to find out about any pain you have and how it is affecting you. Please answer ALL the questions by circling ONE number on EACH scale that best describes how you feel.

1. Over the past week how would you rate your pain?

No Pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week how much has your pain interfered with your daily activities, (housework washing, dressing, driving, walking, climbing stairs, getting in/out of bed/chair/car?

No Interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, family and social activities?

No Interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the last week how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Has made it no worse — Has made it much worse

0 1 2 3 4 5 6 7 8 9 10

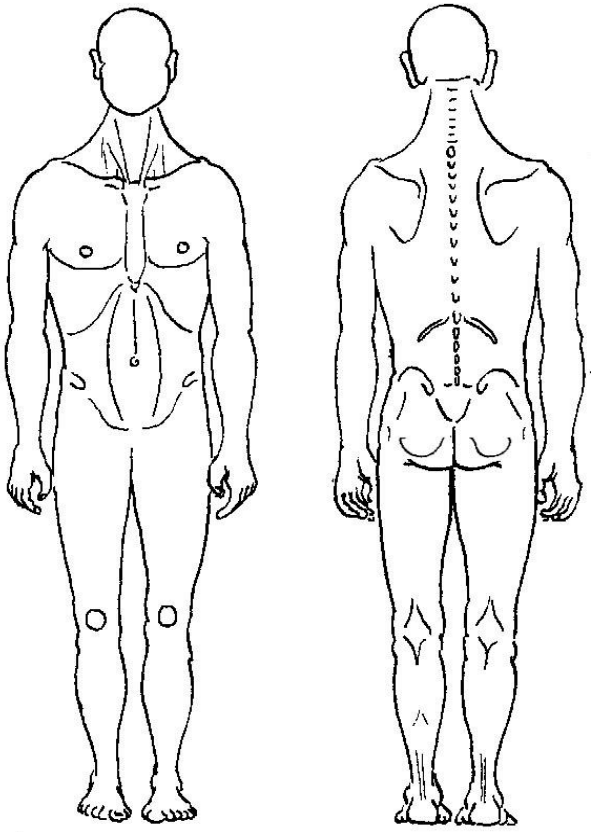
7. Over the past week how much have you been able to control (reduce/help) your pain?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

What is your main reason for consulting us?

Please mark on the diagram below where you feel any pain, discomfort, tingling etc.



INJURIES

Have you had any falls Yes ☐ No ☐

- ☐ As an infant
- ☐ Downstairs or steps
- ☐ Tripped / slipped
- ☐ Sports impact
- ☐ Physical fight
- ☐ Other

Have you been involved in a motor vehicle accident, while driving, as a passenger or pedestrian, even if you were not hurt? Yes ☐ No ☐

Have you ever been knocked unconscious? Yes ☐ No ☐

Have you ever used crutches, a walker, or cane? Yes ☐ No ☐

Have you had any broken bones? Yes ☐ No ☐

Have you had any sprains, strains or dislocations? Yes ☐ No ☐

Have you had any sports injuries? Yes ☐ No ☐

Have you had any impacts, jolts, accidents etc. that you feel specifically may have injured your spine or other joints? Yes ☐ No ☐

Have you ever had any time off work or required bed rest for any physical condition? Yes ☐ No ☐

MEDICAL HISTORY

When did you last consult your GP?

Please list any medical conditions you have or are having investigations for:

Please list any medication you are taking:

Please list any other medications you have taken previously for over 3 months:

Please list any surgery/ operations you have had:

Please note any other times you have been hospitalised for any other condition/ reason?

Please Turn over

Please tick each of the diseases or symptoms that **you have now or have had in the past.**
While some conditions may seem unrelated to the purpose of this appointment, they can affect your diagnosis and treatment. All information is of course confidential

General
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Inability to get to sleep
- ☐ Interrupted sleep
- ☐ Tired all the time
- ☐ Weight gain or loss
- ☐ Inability to lose weight
- ☐ Stressed
- ☐ Light headedness
- ☐ Faints
- ☐ Headaches
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Allergies

Muscles and Joints
- ☐ Arthritis
- ☐ Rheumatics
- ☐ Hernia
- ☐ Low back pain
- ☐ Sciatica
- ☐ Neck pain
- ☐ Pain between shoulder blades
- ☐ Numbness or pain in:
  - ☐ Shoulders
  - ☐ Upper arms
  - ☐ Hands
  - ☐ Legs
  - ☐ Feet
- ☐ Poor posture
- ☐ Spinal curvature/scoliosis
- ☐ Muscle cramps
- ☐ Swollen joints
- ☐ Gout
- ☐ Bursitis

Gastro-Intestinal
- ☐ Difficulty swallowing
- ☐ Low appetite
- ☐ Poor digestion
- ☐ Heartburn or reflux
- ☐ Bloated or tired after eating
- ☐ Indigestion
- ☐ Stomach Ulcer
- ☐ Belching or gas
- ☐ Frequent nausea
- ☐ Vomiting blood
- ☐ Vomiting
- ☐ Pain over abdomen
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Irritable Bowel Symptoms
- ☐ Food intolerances
- ☐ Diverticulitis
- ☐ Black or bloody stools
- ☐ Haemorrhoids
- ☐ Gall Bladder trouble
- ☐ Liver trouble/ Jaundice

Eyes, Ears, Nose, Throat
- ☐ Eye pain
- ☐ Poor vision
- ☐ Squint
- ☐ Glasses/ contact lenses
- ☐ Difficulty hearing
- ☐ Deafness
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Frequent Colds
- ☐ Sinus infection
- ☐ Blocked sinuses
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Jaw pain
- ☐ Jaw clicking or locking
- ☐ Grinding teeth
- ☐ Dental work
  - ☐ Splint
  - ☐ Brace
  - ☐ Teeth removed
- ☐ Snoring
- ☐ Hoarseness
- ☐ Tonsillectomy

Cardio-Vascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High Cholesterol
- ☐ Irregular heart beat
- ☐ Rapid Heart Beat
- ☐ Palpitations
- ☐ Chest pain with activity/ exertion
- ☐ Previous heart problems
- ☐ Rheumatic fever
- ☐ Anaemia
- ☐ Poor circulation
- ☐ Ankle swelling
- ☐ Hardening of the arteries
- ☐ Stroke

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Irregular breathing
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Asthma

Skin
- ☐ Rash
- ☐ Dryness
- ☐ Eczema
- ☐ Fungal infections
- ☐ Moles or spots removed
- ☐ Bruise easily
- ☐ Varicose veins

Nerves and Brain
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Migraine
- ☐ Dizziness
- ☐ Vertigo
- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Anxiety
- ☐ Depression
- ☐ Hyperactivity
- ☐ Learning difficulties
- ☐ Memory declining
- ☐ Concentration declining

Genito-Urinary
- ☐ Bed-wetting
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Difficulty starting urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Getting up _____ times in the night to urinate
- ☐ Kidney infection or stones
- ☐ Kidney disease
- ☐ Venereal Disease
- ☐ Sexual difficulties

Men Only
- ☐ Testicular pain / swelling
- ☐ Prostate trouble

Women Only
- ☐ Menstrual cramps
- ☐ Excessive menstruation
- ☐ Painful periods
- ☐ Irregular cycle
- ☐ Hot flushes
- ☐ Menopause
- ☐ Vaginal discharge
- ☐ Vaginal burning / itching
- ☐ Previous miscarriages
- ☐ Date of last period _____

Are you pregnant ☐ Yes ☐ No

Habits
- ☐ Smoking _____ packs per day
- ☐ Alcohol _____ units per week
- ☐ Coffee _____ cups per day
- ☐ Tea _____ cups per day
- ☐ Fizzy drinks _____ per day
- ☐ Recreational drugs

Exercise
- ☐ Never
- ☐ 1-2 times a month
- ☐ 1-3 times a week
- ☐ 4-6 times a week
- ☐ daily

FAMILY HISTORY

Has anyone in your close family suffered from the following conditions.
Please tick where appropriate and indicate relationship e.g. Father, Mother, Sister etc.

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Anaemia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Joint replacement surgery
- ☐ Arthritis Wear and Tear /Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Low back pain/or surgery
- ☐ Headache/Migraine
- ☐ Allergies
- ☐ Food Intolerances
- ☐ Neuromuscular Disease (i.e. Parkinson's, Multiple Sclerosis)
- ☐ Depression/ Anxiety disorders
- ☐ Dementia / Alzheimer's Disease
- ☐ Learning Disability
- ☐ Mental Disorder
- ☐ Alcohol/Drug dependency
- ☐ Gastrointestinal Problem
  (Gallbladder, Ulcers, Diverticulitis, IBS, constipation, diarrhoea)
- ☐ Prostate disease
- ☐ Liver Disease (Hepatitis, Cirrhosis)
- ☐ Other please state what and who

What would you like your treatment to achieve? Tick appropriate box:

- ☐ **1** Pain Relief
- ☐ **2** Corrective care to restore normal function
- ☐ **3** Maintenance care to prevent reoccurrence of your pain / condition and promote good health

I hereby consent to be examined; I understand that I may be partially undressed and a gown will be provided if needed.

Signed _____ Date _____

Signed by parent or guardian if patient is under 16 or of decreased mental capability

Thank you, please complete and return to reception