Luck's Yard Clinic
CHIROPRACTIC AND HEALTH CARE
FOR THE WHOLE FAMILY

Patient Questionnaire

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 & sexes …….....

Next of kin: Name ..... Tel.....

GP: Name ..... Surgery .....

How did you find out about us? .....

Consent to Examination

I consent to an appropriate physical examination.

Signed..... *Dated*…….....

If you are under 16, this consent should be signed by a parent or legal guardian.

Signed..... *(Parent/Guardian)* *Dated*…….....

Consent to Treatment

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

Signed..... *Dated*…….....

If you are under 16, this consent should be signed by a parent or legal guardian.

Signed..... *(Parent/Guardian)* *Dated*…….....

Where are your problems? *(please also mark the diagram on page 4)*

Neck □ *Shoulder* □ *Arm* □ *Elbow* □ *Wrist* □ *Hand* □ *Finger* □ *Mid-Back* □ *Low-Back* □

Buttock □ *Hip* □ *Upper Leg* □ *Knee* □ *Calf* □ *Ankle* □ *Foot* □ *Toe* □ *(please describe)*

.....

.....

Do you have any of the following symptoms?

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

Dizziness □ *Weakness* □ *(please describe)* .....

.....

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, brothers 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)* .....

.....

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Do you suffer from any of the following problems?

Eye problems □	*Fainting* □	*Dizziness* □
Double vision □	*Nausea/vomiting* □	*Tremors* □
Dental problems □	*Loss of appetite* □	*Inco-ordination* □
Jaw pain □	*Abdominal pain* □	*Night sweats* □
Speech problems □	*PMS* □	*Mood swings* □
Swallowing difficulties □	*Incontinence* □	*Sleep disturbances* □
Acid reflux □	*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* □	*Chronic fatigue / ME* □
Difficulty breathing □	*High BP / heart problems* □	*Blood sugar imbalance* □
Wheezing □	*Headaches* □	*Concentration difficulties* □

Please list all serious illnesses *(previous & current)*.....

.....

Have you ever been hospitalised and why?.....

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 or have you ever used any recreational drugs? .....

.....

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

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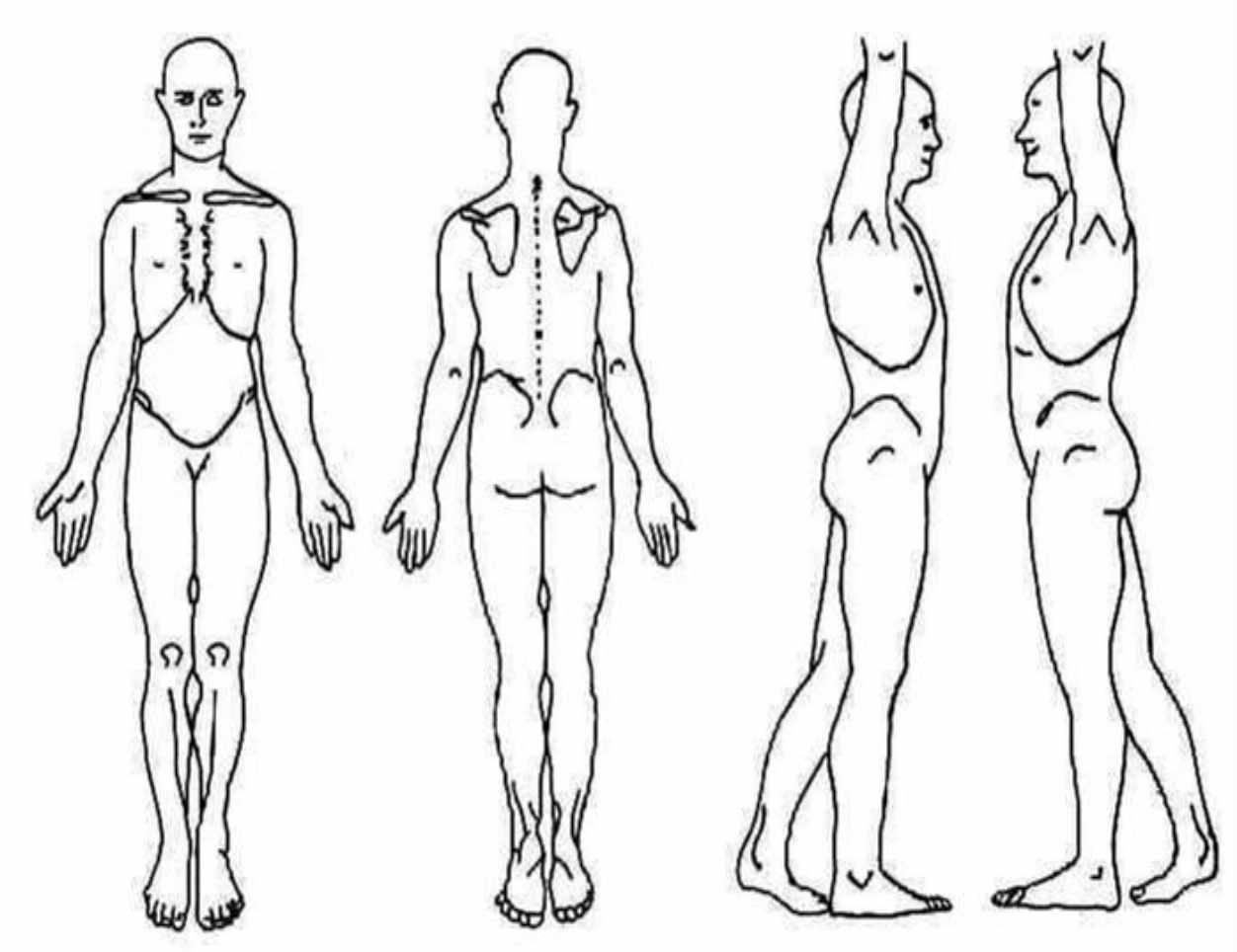
.....

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

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

Patient Symptom Diagram



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

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

Please mark with your own symbol any other symptoms, and note the symbol below: