WESTON CHIROPRACTIC CLINIC

"Our goal is to improve the health of families in our community with natural chiropractic care"

For us to fully understand your condition, it is necessary to complete this form if you require help, please ask a member of staff who will be happy to assist.

YOUR DETAILS

FULL NAME (Mr/Mrs/Miss/Dr/other) _____

Preferred Name: _____ Date of Birth: _____

Address: _____ **Telephone**

_____ Home:(_____)_____

_____ Mobile: _____

Postcode: _____ Work: (_____)_____

Occupation: (Current) _____ E-Mail _____

Marital Status: _____ Spouse's Name: _____

GP Name: _____ Surgery: _____

Do you consent to your General Practitioner being contacted regarding your case? Yes ☐ No ☐

Do you have private medical insurance? Yes ☐ No ☐ Company name _____

(Please advise us if you require receipts to claim back costs from your insurance provider).

Have you had any previous treatment with any of the professions below? Yes ☐ No ☐

Chiropractor ☐ Osteopath ☐ Physiotherapy ☐ Other ☐

What was your response? Excellent ☐ Good ☐ Fair ☐ Poor ☐ No Change ☐

WHO SHOULD WE THANK FOR REFERRING YOU TO OUR CLINIC?

Name _____ Relationship to you _____

Please turn over

Previous Conditions and Family Health

Have you had any operations or been hospitalised for any reason?

Have you broken any bones, or been in a major trauma, e.g. a car accident/fall/knock/ injury? Please specify what injuries were sustained and when it occurred.

Are there any conditions in your family history (e.g. heart disease, circulation problems, diabetes, cancer, rheumatoid arthritis, Osteo-arthritis, back or neck pain, osteoporosis)?

Are you currently taking any medication? Yes □ No □
(If yes, please name the medication or the reason you have to take them)

Is there any other information you would like to tell the chiropractic doctor?

What are you most interested in improving?

□ Overall Health
□ Less Pain/Symptoms
□ Reducing Stress
□ Increasing your Energy and Vitality

How long do you think it will take to achieve your health goals? □ Years □ Months □ Days
How long has it been since you have felt your best? □ Years □ Months □ Days
How long have you been thinking about pursuing your health aims? □ Years □ Months □ Days

Please list your desired health goals and the areas you are most interested in improving

CONSENT

The Chiropractic Doctor is available to answer any queries you may have relating to your care, in person or on the telephone.
I confirm that l agree to appropriate physical examination.
I understand that the information, written or otherwise, is given in the strictest confidence.
I have read and understood the fee scale. No information or patient records will be released to any person, insurance company or other doctor without my consent.

Patients or Parent/Guardians Signature_____ **DATE** _____