Optimal Spine

"getting better, staying better"

Patient ID No.	
CA:	Date:

IT IS IMPORTANT TO ANSWER THE QUESTIONS BELOW AS FULLY AS POSSIBLE

Title __________ Forename ____________________________ Surname ____

Address ____

____

____ Postcode ______________________________

Home Tel _______________________ Work Tel ____________________________ Mobile _____________________________

E-mail Address ____

☐ I agree to Optimal Spine sending me information / newsletters / educational material

Gender __________ Marital Status _______________ Date of Birth _________________ Occupation ___________________

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How did you become aware of the clinic? ____

If referred, please let us have the name of you referrer ____

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Please describe the main problem with which you are attending ____

____

For how long have you suffered? ____

How did it start? ____

What aggravates the condition? ____

What relieves the condition? ____

Please list any previous episodes of similar problems ____

____

Is there any family history of similar problems? No ________ Yes ______ Please give details _________________________

____

____

Please list any operations you have had and / or any current medication

____

____

Have you been involved in any traffic accident or other trauma? And if yes, when? ____

____

GP Name ____

Address ____

____

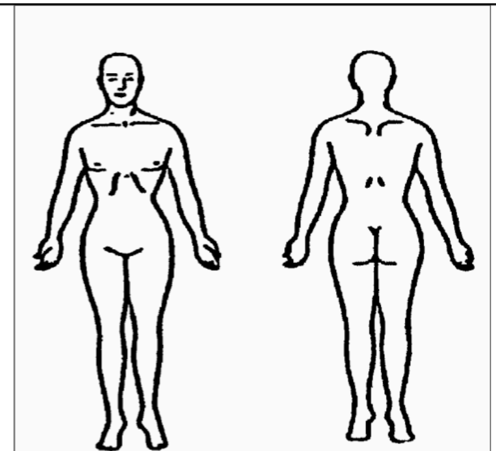
When did you last see your GP? _______________________________________

On a scale of 1 (little) or 10 (a lot) please indicate

How bad is the discomfort	1	2	3	4	5	6	7	8	9	10
How it affects your lifestyle	1	2	3	4	5	6	7	8	9	10

Using the following symbols please mark your areas of pain on the diagrams below

= pain
/// = numbness
* = pins & needles
++ = weakness



Does your condition keep you from any activity? ____
____

What would you like to be able to do once you are feeling better? ______________________________
____

PLEASE TICK IF YOU HAVE SUFFERED WITH ANY OF THESE SYMPTOMS WITHIN THE LAST SIX MONTHS

MUSCULO-SKELETAL SYSTEM

______ Lower Back Problems
______ Pain Between Shoulders
______ Neck Problems / Headaches
______ Arm Problems
______ Leg Problems
______ Sore Muscles
______ Weak Muscles
______ Walking Problems

GASTRO INTESTINAL SYSTEM

______ Poor Appetite
______ Excessive Thirst
______ Recent Weight Loss / Gain
______ Nausea / Vomiting Blood
______ Blood in Stools
______ Abdominal Pain
______ Diarrhoea / Constipation

CARDIO VASCULAR SYSTEM

______ Chest Pain
______ Pain over Heart
______ Difficult Breathing
______ Coughing Blood/Persistent Cough
______ Rapid Heartbeat
______ High/Low Blood Pressure
______ Heart Problem
______ Lung Problems
______ Varicose Veins

GENITO-URINARY SYSTEM

______ Bladder Trouble
______ Painful Urination
______ Blood In Urine/Discoloured Urine
______ Incontinence

FEMALE

______ Breast Pain/Breast Lumps

NERVOUS SYSTEM

______ Numbness
______ Paralysis
______ Dizziness / Fainting
______ Muscle Jerking
______ Depression
______ Stress / Tension

EYE, EAR NOSE AND THROAT

______ Breast Pain/Breast Lumps
______ Breast Pain/Breast Lumps
______ Vision Problems
______ Ear Noises/Hearing Loss
______ Nose Bleeding
______ Sore Gums/Mouth/Throath
______ Hoarseness

DO YOU HAVE MEDICAL INSURANCE? YES / NO IF SO, WHICH COMPANY? ____________________

DO YOU INTED TO CLAIM FOR THE COST OF YOUR TREATMENT? CHIROPRACTIC: YES / NO PHYSIOTHERAPY: YES / NO

PLEASE NOTE: PATIENTS MUST SETTLE WITH THE CLINIC AS TREATMENT IS RECEIVED AND THEN CLAIM FROM THEIR INSURANCE COMPANY

TERMS AND CONDITIONS

If x-rays are taken at any time during your visit to the clinic, the law states that the x-rays shall remain the property of the clinic.
However, you may obtain a copy of your x-rays on CD. This service attracts a charge of £25

I have answered the above form as fully as possible and I have read and understood the terms and conditions of the clinic.
Signed ______________________________ Date: ____________________

Practitioner Use Only

I consent to an appropriate physical examination. If under 16, this consent should be signed by a parent or guardian

By a Chiropractor ____________________ Date __________ By a Physiotherapist ____________________ Date __________

If a parent or guardian print name and relationship to patient — If a parent or guardian print name and relationship to patient

Name ____________________ Relationship ___________ Name ____________________ Relationship ___________

I have been informed of the need for an appropriate x-ray examination and I consent to this.
I have been informed that the cost of x-rays is: ( ) £75 for 1 region ( ) £100 for 2 regions

Signed ______________________________ Date __________

If a parent or guardian print name and relationship to patient Name ____________________ Relationship ___________

Female patients only: Is there any possibility that your may be pregnant? Yes/No _____ Sart date of last menstrual Period _______

I have been given a report of finding 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 the Treatment as outlined to me.

Chiropractic ____________________ Date __________ Physiotherapy ____________________ Date __________

If a parent or guardian print name and relationship to patient — If a parent or guardian print name and relationship to patient

Name ____________________ Relationship ___________ Name ____________________ Relationship ___________

THERAPY PATIENTS: I consent to have Massage Therapy / Reflexology Name ____________________ Date __________