Back In Form Chiropractic Clinic
65-67 Commercial Rd, Poole
BH14 0JB
Tel: 01202 733355

PATIENT DETAILS

Case Number: _____

Date: _____

PERSONAL DETAILS

Surname:……. Title:…….. Date of Birth:…….

Forename(s):……... Marital Status:……

Full Address:……....

……Post Code:……Email:……

Telephone: Home:……..Work:……..Mobile:…….....

Height:……..…….. Weight:……..… Number of children:…….....

Do you have medical insurance? YES/NO Which company?……,,

How did you hear about us? (If recommended, by whom?) ……

EMPLOYMENT DETAILS

Occupation:…… Employer:…..…… Number of years in job:……....

Nature of work - Physical/Sedentary/Mixed If retired, what was you occupation?.....

HEALTH DETAILS

Name of GP:……Address:……..

Details of any medication you are taking:……

Have you received any other medical treatment recently? YES/NO Details:……..

……

Any Road Traffic or other Accidents:……

Any broken bones – What and when:……

Any operations – What and when:……

Do you smoke? YES/NO How many per day?…... Do you drink? YES/NO How many units per week?.....

Date of last prostate exam:……. Date of last breast exam:…… Date of last cervical smear:……

Details of regular exercise that you take:……

Hobbies:……

I understand that any x-rays or other diagnostic tests undertaken by this clinic remain the property of the clinic, and will only be released to other parties with my prior agreement.

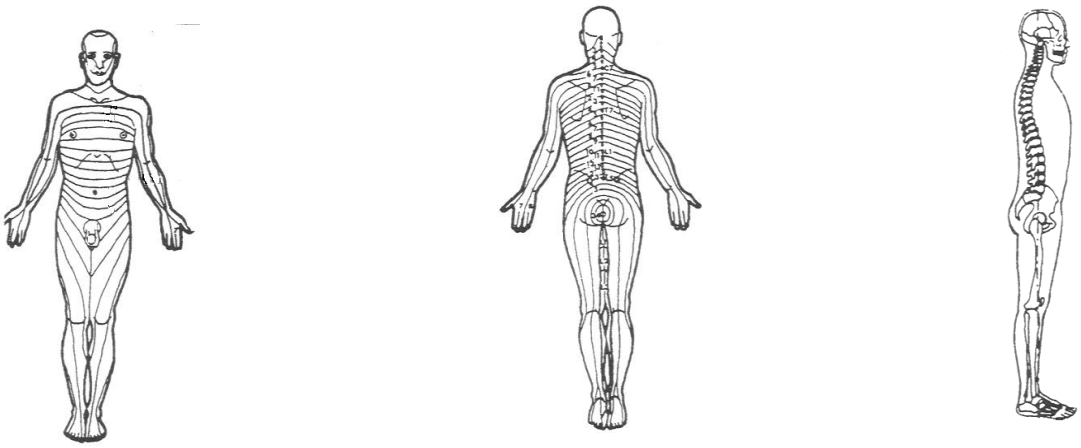
Do you give consent to your GP being kept aware of your progress? YES/NO

Have you or any members of your family, suffered from any of the following:

	SELF	BLOOD RELATIVE (Please specify relation)
Heart problems:		
Blood Pressure problems:		
Stroke:		
Cancer:		
Liver/Kidney problems:		
Digestive/Bowel problems:		
Bladder/Genitourinary problems:		
Diabetes:		
Circulation problems:		
Neurological problems:		
Migraine/Headaches:		
Dizziness/Balance problems:		
Tinnitus:		
Eyes/Ears/Nose/Throat problems:		
Arthritis/Rheumatism:		
Osteoporosis:		
Respiratory/Asthmatic/Breathing problems:		
Allergies/Skin Disorders:		
Other:		

Thyroid/Hormonal problems:.....

Please indicate the location of the symptoms that you have.



On a scale of 0-10, in which box would you put the pain level for your primary complaint? X at worst O at best

No Pain	0	1	2	3	4	5	6	7	8	9	10	Maximum pain

I hereby give my consent to be examined by the chiropractor and for a record of the examination, and any treatment given, to be kept at Back in Form Chiropractic Clinic.
(If you are under 16 years of age, this consent should be signed by a parent or legal guardian.)

Signed:.....Date:.....