PEACEHAVEN CHIROPRACTIC

Name: (Mr/ Mrs/ Ms/ Miss/Other)……………………………........................... Date:…………

Age: ……………Date of Birth: ………………….. Address: ……………………………......................

…………………………….…………………………………..........................Postcode: …………………….

Marital Status: ……………………………. Number and age of children: ………………………………...

E-mail address: ………………………………....................(From time to time we may e-mail information about clinic news and health tips for you and your family. You can unsubscribe at any time.)

Tel no: ……………………… Mobile no: ………………………Work no: ……………………………

Occupation: ……………………… Medication: ……….………………………………….......................

(Please leave blank if you do not wish us to contact your GP)

GP name: ………………………….. GP address: ……………………………......................................

General information about your health history **Please provide any extra details where relevant**

How many hours do you exercise per week?…………**H**ow much water do you drink per day? ……………

Have you ever had a road traffic incident? YES/NO Please give details …………….…………………………

Do you drink alchohol? YES/NO **H**ow much per week? ……**A**re you pregnant? YES/NO

Do you smoke? YES/NO How many per day? ………**H**ave you ever broken any bones? …………………

What is your main complaint? …………………………...

Is this your first episode? YES/NO If no how many previous episodes have you had? ………

On a scale of 0 -10 (where 0 is none and 10 is the worst you can imagine) please grade the following:

Overall Health

0	1	2	3	4	5	6	7	8	9	10

Any further comments: ………………………………...

Pain levels for your main complaint

0	1	2	3	4	5	6	7	8	9	10

Do you suffer from any of the following conditions: **Please turn over**:

	Yourself	Close family member
Headaches/Migraine		
Neck/Back Pain		
Numbness/tingling		
Arthritis/joint complaints		
Bowel/bladder complaints		
Chest pain/ lung complaints		
Shortness of breath		
Cancer		
Heart/ blood pressure		
Circulation/ blood clotting disorders		
Recent change in weight		
Depression		
Trouble swallowing/difficulty breathing		
Dizziness		
Head or Neck Trauma		
Recurrent infection		
Collagen disorders		
Transient ischemic attacks (TIA)		
Stroke		
Epilepsy/ other nervous conditions/ MS		
Do you use oral contraceptive pill		
Do you use any supplements		

CONSENT AND DATA PROTECTION POLICY

I have had a report of findings and have had my condition explained to me. I have been advised that chiropractic is a safe form of therapy and have had the risks explained. I consent to having treatment at Peacehaven Chiropractic. Upon completion of the Patient Details Form, Data and Consent form, all paper files and information therein may also be electronically scanned and stored on computer file for as long as the patient remains a patient of the clinic and thereafter for a period of seven years. Information provided will be treated as confidential and will not be given to any other person(s)/ organization(s) without the written consent of the patient concerned. Information will be accessible only by staff of the clinic that are directly involved in the data entry and processing of patients record. I, the undersigned (or authorized guardian) acknowledge that I have read the data protection policy (above) and do hereby give consent to the practitioner/chiropractor to maintain records for the purposes outlined within the policy.

PATIENT (PRINT NAME)___________________________ SIGNATURE____________________________ DATE__________

For office use only	
GP letter YES/NO	Chiropractor
GP letter done YES/NO	Previous Chiro/care
Database YES/NO	Referral Source Specific