Confidential Patient History

Welcome to Lincs Chiropractic Clinics in Boston, Horncastle, Louth and Skegness. To enable us to assist you in reaching your health goals please take a few minutes to answer the following questions as accurately as you can. Leave out any questions you do not wish to answer. Your answers will help us decide if chiropractic treatment can help you.
Please fill out both sides of the questionnaire

PATIENT DETAILS

Title: Mr/Mrs/Master/Miss/Ms/Other _____

Surname: _____ First name(s): _____

Birthday: _____ Age:_____ M □ F □

Address: _____

Town: _____ Postcode: _____

Occupation: _____ Employer: _____

Email Address: _____

Phone (H): _____ Preferred □ (M): _____ Preferred □
(W): _____ Preferred □

Status Single □ Married □ Cohab. □ Widow (er) □ Separated/Divorced □

Partner's Name:_____ Children and Ages: _____

Is there any chance that you are pregnant? □ Yes □ No

GP Name and Clinic: _____

Who recommended / Referred you to our clinic? _____

Are you claiming the costs of care through a 3rd party? □ Yes □ No If yes, who?
_____

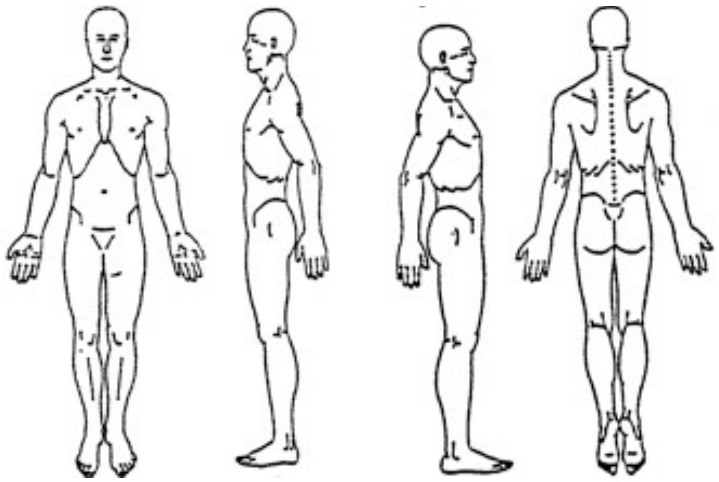
If you have had Chiropractic Care before, please complete the following:
Name of Chiropractor: _____ Located: _____
When was your last adjustment: _____ Did you have x-rays: _____
How did you respond? No response to care □ Average results □ Great results □
What type of care were you under: □ Don't know
□ Initial Intensive Care Frequency of care _____
□ Wellness or Maintenance Care Frequency of care _____

Health History / Loss of optimal health

Please tick the reason(s) you are seeking Chiropractic care:

1. Optimal health and wellness / prevention □
2. Reactivation (previous patient here or elsewhere) and wishing to re-commence care □
3. Attending for specific complaint(s) □ Please explain below, ***and draw on the diagram below***:

_____ When did it start _____, or is it ongoing? □



PAIN SCALE
Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

How did it start? _____ Have you had it before? _____
Is the pain □ Sharp □ Dull □ Stabbing □ Burning □ Throbbing □ Like pins & needles
Does the pain spread? □ Yes □ No If yes, to where? _____
Do you have numbness or weakness? □ Yes □ No If yes, where? _____
Is the pain worse when you cough or sneeze? □ Yes □ No If yes, where? _____
Is the pain getting progressively worse? □ Yes □ No □ Constant □ Comes & goes
What aggravates the problem? _____ What relieves the problem? _____

Who else have you seen about the problem? _____

Please list any operations you have had:
1. _____ 2. _____ 3. _____

Please list any serious illnesses you have had:
1. _____ 2. _____ 3. _____

Please list any traumas / accidents you have had:
1. _____ 2. _____ 3. _____

Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind? _____

Medication you currently take:_____

Do you have loss of control of your bowel or bladder, or numbness in the "saddle" area? _____

Other health concerns:

1. _____ When did it start _____, or is it ongoing? □
2. _____ When did it start _____, or is it ongoing? □
3. _____ When did it start _____, or is it ongoing? □

General health questionnaire:

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of your condition. Please tick the appropriate box if you have had any of the following symptoms.

Leave blank any that do not apply.

Please tick (one box only) based on if the symptom occurs:
(O=Occasionally, F= Frequently, C=Constantly)

O	F	C	**Head/Neck**
			Headaches
			Light Headedness
			Loss of Balance
			Hearing Loss
			Ringing in Ears
			Buzzing in Ears
			Neck Pain / Ache
			Grating / Cracking in neck

O	F	C	**Shoulder, Arm, Fingers, Hands**
			Pain
			Pins and Needles
			Numbness
			Weakness / Loss of strength
			Restricted movement
			Swollen Joints

O	F	C	**Chest and Abdomen**
			Pain/ tightness in chest
			Pain around ribs
			Shortness of breath
			Wheezing
			Rapid heart beat
			Thumping Heart beat
			Stomach/Abdominal pain
			Belching or excessive wind
			Nausea
			Abdominal organ problems
			Constipation or diarrhea
			Hernia
			Groin or pelvic pain

O	F	C	**Low Back, Legs or Feet**
			Pain
			Pins & needles
			Numbness
			Restriction of movement
			Swollen Joints

O	F	C	**Geneto-Urinary System**
			Urinary problems or infections
			Difficulty starting or stopping urination
			Loss of control or urination
			Bed wetting
			Prostate problems

O	F	C	**Females Only**
			Painful, tender or lumps in breasts
			Menstrual problems or abnormalities
			Menopausal symptoms
			Painful intercourse

O	F	C	**General Symptoms**
			Allergies, sinus problems etc.
			Excessive fatigue
			Chills, fever
			Fainting
			Sudden, recent loss of weight
			Depression or mental illness
			Excessive sweating
			Vascular disorders
			High blood pressure (hypertension)
			Low blood pressure

O	F	C	**Neurological**
			Tremors
			Loss of balance
			History of stroke, TIA, thrombosis etc.
			History of cardiovascular disease

Please tick if **<u>either of yourself (S) or family (F)</u>** have had the following:

S	F	
		Cancer
		Vascular or heart disease
		Arthritis
		Neurological conditions
		Other serious illness

<u>Consent to examination</u>

I consent to an appropriate chiropractic examination.

_____ _____

Patient Signature Date

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** 0 /40

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