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?
_____

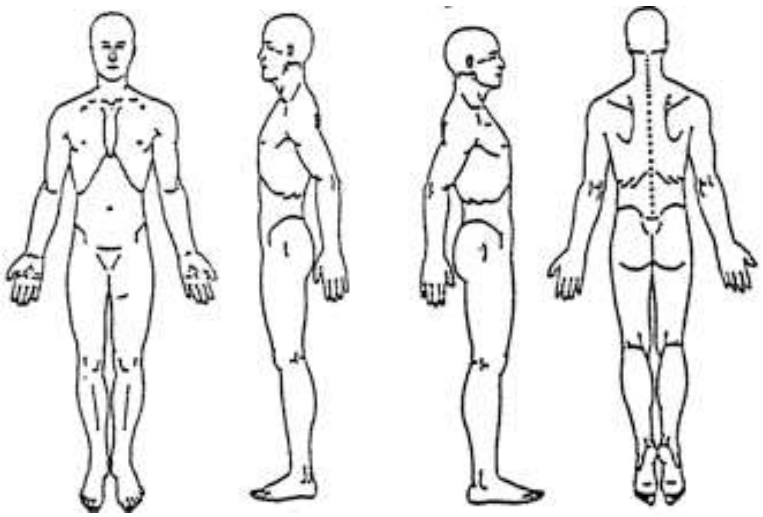
If you have had Chiropractic Care before, please complete the following:
Name of Chiropractor: _____ Located: _____
When was your last adjustment: _____ Did you have x-rays: _____
How did you respond? No response to care □ Average results □ Great results □
What type of care were you under: □ Don't know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

Informed consent to examination (if applicable)

I hereby acknowledge that all of the information I have provided is accurate to the best of my knowledge. I also give my consent to any examination deemed appropriate/necessary by the clinician.

_____ _____

Patient Signature Date

Privacy Policy *May 2018*

As a patient of Lincs Chiropractic we will need to hold personal information about you (name, address, medical history, GP, etc). These are normally stored as digital records. This data is held solely for the purpose of providing safe and effective care. Your data is not used for marketing or any other purpose. The Clinic Directors are the data controllers and are responsible for their accuracy and safe-keeping. Please help to keep your records up to date by informing the clinic of any change of circumstances.

All information about you is held securely and appropriate safeguards are in place to prevent accidental loss, or access without consent. Clinic staff will have access to you records to enable them to do their jobs. From time to time information may be shared with others involved in your care, if it is necessary. Anyone with access to your records is properly trained in confidentiality issues.

In almost all circumstances you will be required to give written consent before information is released – such as the reports for insurance, solicitors, GP letters etc. In exceptionally rare circumstances we may be required by law to release your records, for example if a court order is presented, or there is an imminent risk to the life of yourself or others.

To ensure your privacy, we will not disclose information over the telephone, fax, or email unless we are sure that we are communicating directly with you. Information will not be disclosed to family and friends unless we have prior written consent and we do not leave messages involving personal data with others.

You have a right to access all your records held at the clinic, and there is usually no fee payable. If paper or digital copies of your health records are required, the charge for providing copies will not exceed £50, (but is usually significantly less). All requests for personal data must be made in writing by the patient or legal guardian to

Scanned requests can be emailed to chiro@lincschiro.co.uk. All requests must be signed and dated, and we may phone you to confirm the request prior to release of any personal information.

Copies of our full data protection policy are available on request or on our website www.lincschiro.co.uk.

Informed consent to treatment (if applicable)

Please read this form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as for example joint manipulation, adjustment or mobilisation, are advised to inform patients that there are or may be some risks associated with such treatment. In particular:

4. While rare, some patients have experienced muscle soreness, ligament sprains or strains, or rib fractures following spinal adjustments.
5. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and/or mobilisation. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million to 2 million treatments.
6. There have been reported cases of intervertebral disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatment provided at this clinic, including spinal adjustment or manipulation, has been the subject of much research conducted over many years and has been demonstrated to be appropriate and effective treatment for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches, and other similar symptoms. Treatment provided at this clinic may also contribute to your overall wellbeing. The risk of injury or complication from manual treatment is substantially lower then the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgment: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of the treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation to the joints of my spine (neck and back), pelvis, and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatment at this clinic.

Date:_____/_____/_____

Patient/Guardian Signature _____

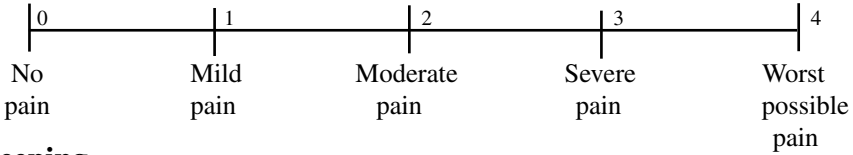
Patient/Guardian Name (print) _____

Functional Rating Index

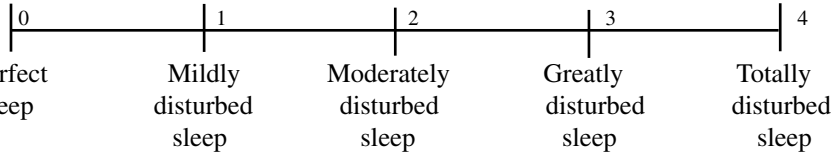
For use with **Neck and/or Back Problems** only.

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.**

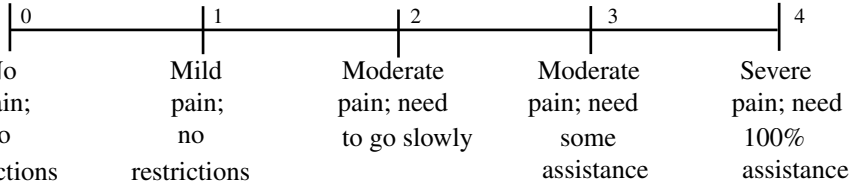
1. Pain Intensity



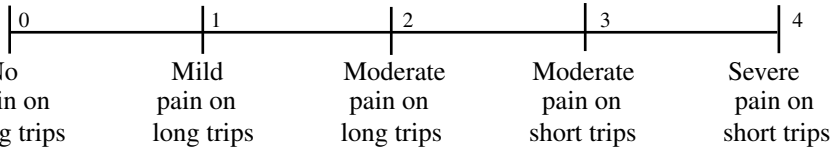
2. Sleeping



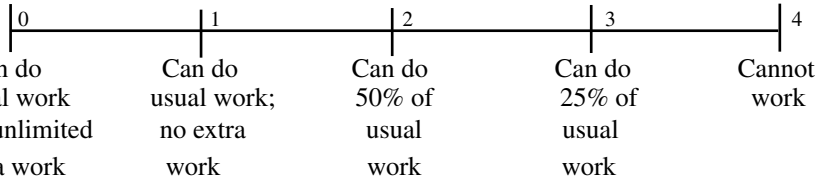
3. Personal Care (washing, dressing, etc.)



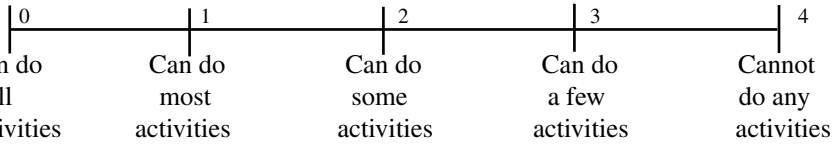
4. Travel (driving, etc.)



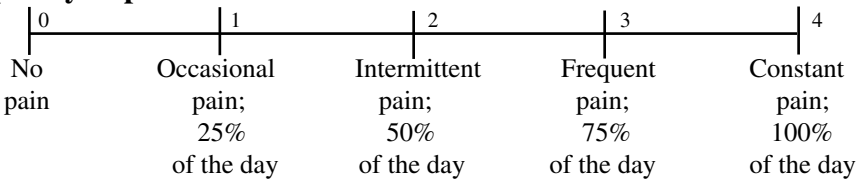
5. Work



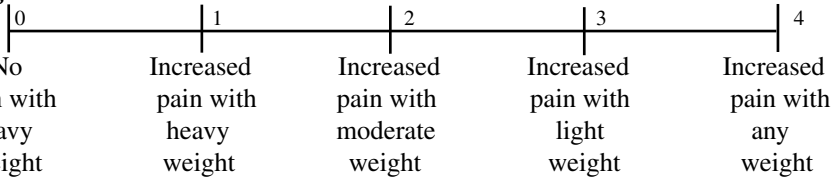
6. Recreation



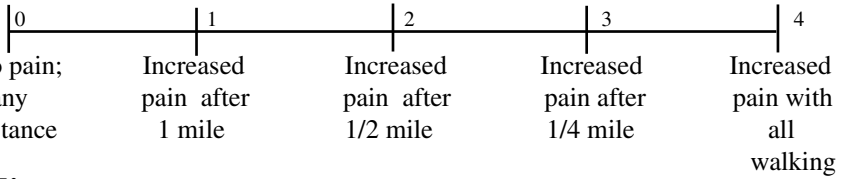
7. Frequency of pain



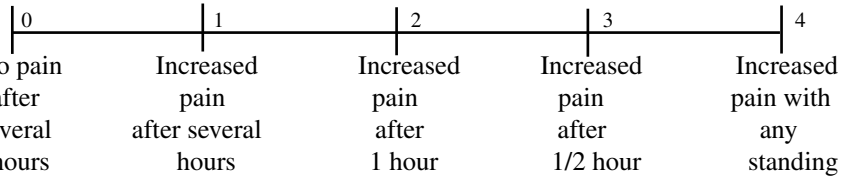
8. Lifting



9. Walking



10. Standing



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

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_____ _____

Signature **Date**