C3 Chiropractic Clinics – Chiropractic Care New Patient Form

Cardiff :223 – 225 Pantbach Road, Cardiff CF14 6AE 029 20627888 Bridgend: 7 Gaylard Buildings, Court Road, Bridgend CF311BD 01656 663999

Title: Dr/Mr/Mrs/Miss/Ms …… Forename: …… Surname: ……

Address: …… Postcode: ……

Phone: …… (mobile): …… Email: ……

How did you hear about the clinic: Website ☐ Friend ☐ GP Ref ☐ Other……

Date of Birth: …… Your Age: …….. Height: …… Weight: ……

GP Name and Address: ……

ABOUT YOU AND YOUR REASON FOR SEEKING CHIROPRACTIC CARE:

What is your occupation? ……

Does your job involve: Bending Sitting Driving Lifting etc ……

Do you have children? Yes ☐ No ☐ If yes how many, ages etc? ……..

How active are you normally? Very Active ☐ Moderately Active ☐ Not Active ☐

Where is your present complaint? neck; upper back; lower back; shoulder; arm; leg; knee; hip; ankle; other

……

Have you suffered from this complaint before? Yes ☐ No ☐ If yes when: ……

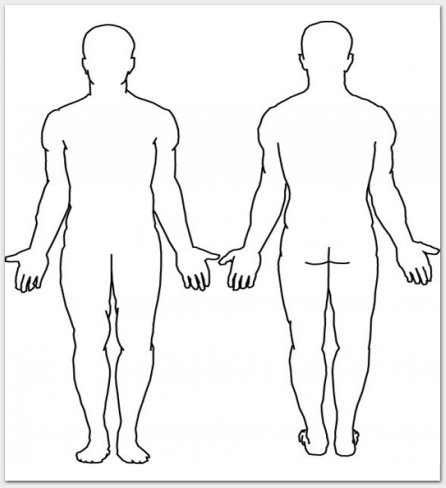
When did it begin? …… When is it worse: Morning ☐ Afternoon ☐ Evening ☐ Night ☐

Was your complaint due to a trauma or was it a gradual onset? Trauma ☐ Gradual onset ☐

Have you seen your GP for this complaint: Yes ☐ No ☐ If yes have you had X-Rays/MRI Scans? ☐ Blood Tests ☐

Are you currently in involved in a litigation case as resulut of this complaint? Yes ☐ No ☐

Have you been off work or school due to this complaint: Yes ☐ No ☐ If yes how long for? ……



Draw on the diagram all areas of pain you are experiencing:	**List your medication:** ……
CP = Constant Pain	……
P = Pain	……
S = Stiffness	……
N = Numbness	……
B = Burning	……
W = Weakness	……

Mark on the scale the severity of your pain: 0 (no pain) – 10 (severe pain) **0….1…..2….3….4….5….6….7…..8…..9….10**

Do you have more pain on rest or movement? Rest ☐ Movement ☐ Do you have pain at night? Yes ☐ No ☐

Do you have night sweats? Yes ☐ No ☐ What makes it worse? …… What makes it better? ……

Have you received any medical or other treatment for this complaint? Yes ☐ No ☐

If yes please state what treatment and when: ……

FEMALE PATIENTS:

Is there a possibility that you are pregnant? Yes ☐ No ☐ Last menstral cycle: ……

Last Smear Teat: …… Regular Self Breast Examination: ……

MALE PATIENTS:

Have you had your prostate checked? Yes ☐ No ☐ If yes PSA level was: ……..

Regular Self Testicular Examination: ……

ABOUT YOUR HEALTH – HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

Liver/Kidney Problems	☐	HIV	☐	Heart/Stroke	☐	Lung/Breathing	☐
Bowel Problems	☐	Bladder Problems	☐	Digestion Problems	☐	Reproductive Problems	☐
Circulation Problems	☐	Diabetes	☐	Epilepsy	☐	Allergy/Skin Disorders	☐
Nervous Disorders	☐	Osteoporosis	☐	Head Injuries	☐	Blood Pressure	☐
Migraines/Headaches	☐	Dizziness	☐	Tinnitus	☐	Ear/Nose/Throat Problems	☐
Multiple Sclerosis	☐	Depression	☐	Hepatitis	☐	Connective Tissue Disorders	☐
Cancer:	☐	Cancer Type ……		Osteoarthritis	☐	Rheumatoid Arthritis	☐

Any other condition not listed?……

Any: Hospitalisations; Surgeries; Broken Bones? ……

Do you want to: Just get out of Pain ☐ Get out of pain and stop it returning ☐ Keep healthy once you are right? ☐

PATIENT CONSENT SECTION (Mandatory):

To diagnose your condition the chiropractor may need to undertake an appropriate physical examination. Do you give your consent? Yes ☐ No ☐ The clinic may need to contact your GP do you give your consent? Yes ☐ No ☐

Data Protection Policy:

I have read the C3 Clinics Data Protection Policy and give my consent to the Clinic to maintain records for the purposes outlined within the policy.

Signed: …… Date: ……

Late Cancelation Policy:

I have read the C3 Clinic's late cancellation policy and understand that if I need to cancel or reschedule an appointment I have booked, a minimum of 12 hours' notice is required. If I cancel or reschedule my appointment (or fail to turn up for my appointment) a fee will be payable.

Signed: …… Date: ……

Treatment Consent:

I have received an explanation of my condition and understand the treatment options and likely benefits. I have been advised of the possible side effects associated with chiropractic treatment and understand the risks. I hereby give my consent to chiropractic treatment.

Signed: …… Date: ……

(To be signed by a parent or guardian in case of a minor)