# Lawrence Chiropractic Clinics

| CASE NUMBER | |
|---|---|
| DATE | |

## NEW PATIENT DETAILS FORM

*Quality Care for a Fitter Future*

**TO BE COMPLETED BY PATIENT**

All details are confidential and will not be shared with any third party without written consent

PLEASE WRITE CLEARLY IN BLOCK CAPITALS

Surname: _____ Mr, Mrs, Ms, Miss, Other: _____ Age: _____

Forename(s): _____ Date of Birth: _____

Full Address: _____

_____ Post Code: _____

Email: _____ Marital Status: _____

Names and ages of children: _____

Mobile: _____ Home: _____ Work: _____

How did you find out about the clinic (please be specific): _____

EMPLOYMENT DETAILS

Occupation: _____ Number of years in current job: _____

Employer: _____

HEALTH DETAILS

Name of GP: _____ Telephone number: _____

Address of GP: _____

ADDRESSING WHAT BOUGHT YOU INTO THIS OFFICE

| What are the main reasons for this appointment? | Severity (mild 0-10 worst) | Has this happened before? |
|---|---|---|
| 1. _____ | _____ | Y / N When? _____ |
| 2. _____ | _____ | Y / N When? _____ |
| 3. _____ | _____ | Y / N When? _____ |
| 4. _____ | _____ | Y / N When? _____ |

Elaborate: _____

_____

_____

_____

_____

When did you first notice these problems? _____ Was it Sudden OR Gradual? _____

Do you believe any event/illness contributed to this? Y / N Explain: _____

_____

Are these conditions interfering with any of the following? Work / Sleep / Digestion / Daily Routine / Sports / Other

Please Explain: _____

## GENERAL HEALTH

Have you had **ANY** sprains, broken bones, major falls or surgery (including dental)?

Type:_____ When/Age?_____

Type:_____ When/Age?_____

Type:_____ When/Age?_____

Type:_____ When/Age?_____

Have you had **ANY** accidents and/or injuries: car, sports or other especially related to your current problems?

Type:_____ When/Age?_____

Type:_____ When/Age?_____

Type:_____ When/Age?_____

Type:_____ When/Age?_____

**Please CIRCLE the appropriate answer for each of the following questions: DO YOU:-**

| | | | | |
|---|---|---|---|---|
| Exercise? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Play contact sports? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Sit for long periods? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Regularly bend & lift? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Spend over 2 hours per day at a computer? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |

## DIET

In as much detail as possible, please describe your typical daily diet

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Fluids:_____

How many cups of caffeinated coffee/tea do you drink per day?_____ Do you smoke Y / N _____ per day

How many units of alcohol do you drink per week (approximate measures are given below)? _____

*Pint of beer = 2 units / Bottle of beer = 1.5 units / Glass of wine = 1.5 units / Bottle of wine = 10 units / Shot = 1 unit*

## CURRENT MEDICATION

Have you been taking any medications/drugs (prescription/non-prescription) in the last 12 months?

Name:_____ Dose/Frequency:_____ Why?_____

Name:_____ Dose/Frequency:_____ Why?_____

Name:_____ Dose/Frequency:_____ Why?_____

Name:_____ Dose/Frequency:_____ Why?_____

Name:_____ Dose/Frequency:_____ Why?_____

Name:_____ Dose/Frequency:_____ Why?_____

**From childhood to present, have you ever had any of the following (tick the box of any that apply)?**

- ☐ Kidney problems
- ☐ Liver problems
- ☐ Heart problems
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lung problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer
- ☐ Migraines
- ☐ Headaches
- ☐ Depression
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Allergies
- ☐ Dizziness
- ☐ Tinnitus
- ☐ Concussion
- ☐ Clicking jaw
- ☐ Fatigue
- ☐ Circulation problems
- ☐ Loss of Sleep
- ☐ Shingles
- ☐ Constipation
- ☐ Gall bladder problems
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody stool
- ☐ Bladder trouble
- ☐ Urinary tract infections
- ☐ IBS
- ☐ Diarrhoea

Men Only

- ☐ Prostate dysfunction
- ☐ Sexual dysfunction
- ☐ Testicular pain
- ☐ Testicular lumps

Women Only

- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/infections
- ☐ Breast pain/lumps

When was your last period? / /

Are you pregnant? Y / N

**Poor posture leads to poor health and often indicates a spinal problem. How do you rate your posture?**

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

## HEALTH STATUS

**Rate out of 10 (1 = poor, 10 = outstanding) your level of satisfaction in your…**

| | | | |
|---|---|---|---|
| Flexibility | Sleep quality | Ability to recover from stressful events | |
| 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | |
| Digestion | Posture | Overall health | |
| 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | |
| Energy levels | Immune system function | Stress | Exercise frequency |
| 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 | 1.2.3.4.5.6.7.8.9.10 |

## HEALTH GOALS

**Which of these health goals is most important to you?**

1.) Pain control/relief 2.) Energy level and fatigue 3.) Quality of sleep 4.) Memory and ability to focus

4.) Digestion 5.) Nutrition 6.) Mood 7.) Stress levels 8.) Allergies and immune system

9.) Understanding more about health and how you and your family can keep healthy

**What would you like to be able to do that your current condition is preventing you from doing?** _____

_____

_____

**Have you been forced to make positive changes in your life due to this condition (e.g. eating better, increased exercise, less alcohol or drugs, avoiding contact sports etc)? If yes, what?**_____

_____

**FEES AND HEALTH INSURANCE**

Our clinics request that fees are paid at the time of your appointment. Whilst chiropractic fees can be reclaimed through most health insurance companies, it is your responsibility to check that you can reclaim these costs. Some health insurance companies require GP referral and/or an authorisation number before treatment costs can be claimed. We will provide a receipt for your chiropractic treatment costs which you can submit to your health insurance company.

**DATA PROTECTION**

We use your information in compliance with the General Data Protection Regulation (GDPR). All of your personal details are stored securely and are used only for the purposes necessary for your care. Full details of how we comply with General Data Protection Regulation can be found in our clinic reception

**INFORMED CONSENT**

There are many concerns about the safety of procedures we undergo routinely, the environment we live in and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Lawrence Chiropractic Clinics will enhance your experience. Some people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.

If you are [or have been] taking anticoagulant [blood thinning] medication or steroids then it is important to tell your chiropractor this prior to commencing care.

There are always risks associated with any therapeutic intervention. The risk of permanent injury from manual spinal adjustment is approximately 1 in 2.5 million. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for aches and pains is approximately 1 in 333. Statistically there is more chance of being hit by lightning than experiencing permanent damage from a manual adjustment. We must explain these risks to you so that you can make an informed decision about commencing or continuing your care. If you have any further concerns please ask your chiropractor.

The adjustments and care you receive here at Lawrence Chiropractic Clinics will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

I have read the above and give authority to Lawrence Chiropractic Clinic to commence/continue chiropractic care for either myself or my dependent [whichever is applicable].

Name (Please Print):_____

Signed:_____ Date_____