Sykes Verwey Centre
Chiropractic & Sports Injury
Est. 1963

# CONFIDENTIAL NEW PATIENT FORM

**PERSONAL DETAILS –** Please fill out clearly

Surname: _____ Forename(s): _____ Date of Birth: _____ Age: _____

Full Address including Post Code:

Marital Status: _____ Number of Children: _____ Age(s) of Children: _____

Height: _____ Weight: _____ Have you recently lost weight? _____

## CONTACT DETAILS

(Please tick the box next to your preferred method of contact)

☐ Home Tel Number: _____

☐ Mobile Number: _____

☐ Email Address: _____

**REFERRALS –** How did you come across the clinic?

**Recommended by a Friend/Colleague?** ☐ (Please add their name) _____

**Google Search** ☐ **Previous Patient** ☐ **Knew we were here** ☐

**Social Media?** ☐ (Which platform?) _____

Do you have medical insurance? **YES** ☐ **NO** ☐ Which company? _____

Will you be claiming? **YES** ☐ **NO** ☐

Are you under any current legal claim? _____

**EMPLOYMENT –** To get a picture of your activity levels please answer the following

Occupation (Previous if Retired): _____ Employer: _____ Full Time/Part Time

Number of years in job: _____ Previous Occupation if less than two years: _____

## PLEASE TICK THE BOX NEXT TO YOUR MAIN ACTIVITY AT WORK

**Desk/Office based** ☐ **Manual/Physical Job** ☐ **On feet all day** ☐ **Other:** _____

Driving job: Please list the average mileage per year? _____

Office based: How many hours per day on average? _____

On feet/manual work: Please list activity that affects complaint? _____

## LEISURE / ACTIVITY

Do you play sport or do any regular physical exercise (inc. walking)? **YES** ☐ **NO** ☐

Please list what type: _____ Amount per week: _____

Do you have any hobbies that you enjoy? (Please list)

Do you smoke? **YES** ☐ **NO** ☐ (per day) _____ Do you drink? **YES** ☐ **NO** ☐ (units per week) _____

What position do you sleep in? **Side** ☐ **Front** ☐ **Back** ☐

Do you have a good ergonomic desk set up at work/home? **YES** ☐ **NO** ☐

Do you cross your legs when you sit? **YES** ☐ **NO** ☐

## YOUR COMPLAINT/ CONDITION / REASON (For seeking Chiropractic help)

Please mark your main complaint today:

**Lower Back** ☐ **Upper Back** ☐ **Neck Pain** ☐ **Headache/Migraine** ☐

**Other:** _____

**Please describe your present problem in your own words:**

When did it first start? _____

What is the quality of the pain?

**Burning** ☐ **Tingling** ☐ **Aching** ☐ **Stabbing** ☐ **Numbness** ☐ **Other:** _____

When is it the worst? **AM** ☐ **PM** ☐ **Evening** ☐ **At Night** ☐

Does the pain wake you from a sound sleep? **YES** ☐ **NO** ☐

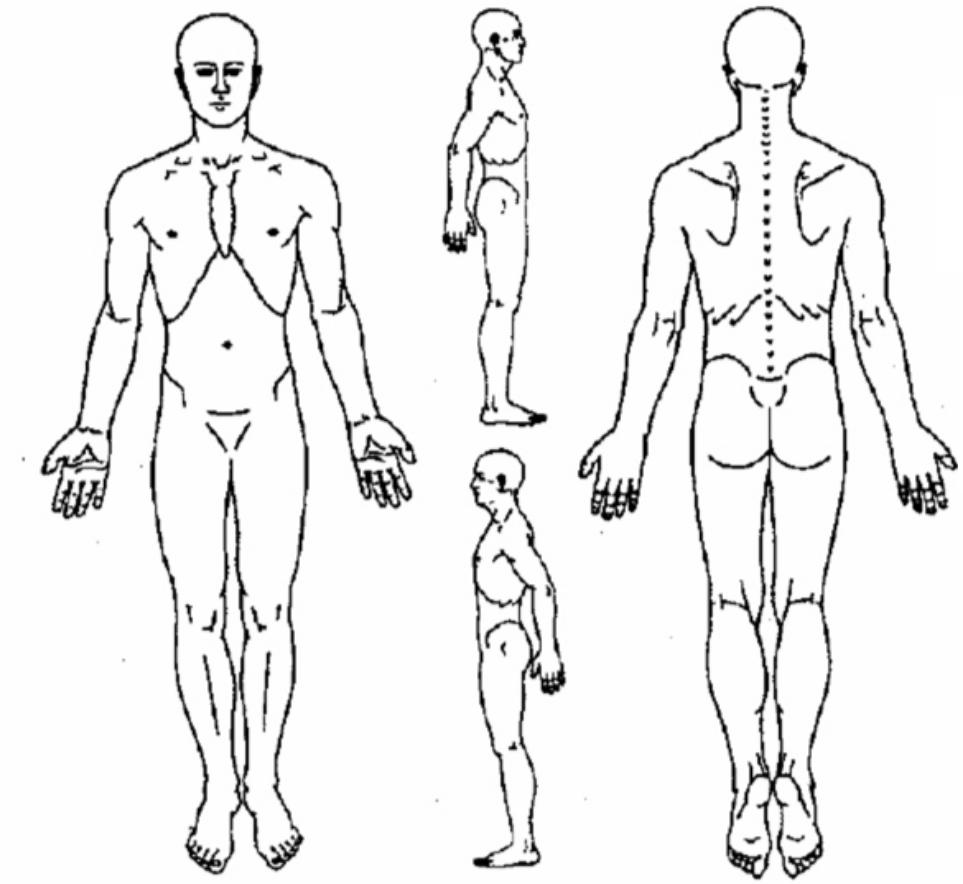
## DO YOU HAVE ANY OTHER SECONDARY COMPLAINTS

Does the pain radiate to other areas?

**Leg** ☐ **Arm** ☐ **Head** ☐ **Other:** _____

## PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using appropriate symbols:



Numbness - - - - - -

Pins & Needles o o o o o

Burning ^ ^ ^ ^

Aching x x x x

Stabbing ⊗ ⊗ ⊗ ⊗

0 ——————————— 10

Please mark on the scale where your pain level is with a cross.

## MEDICAL HISTORY

Have you seen your GP about this complaint and had any examination to date i.e blood test? _____

Have you seen a consultant about your complaint and what treatment have you had? _____

Have you been referred for any imaging (x ray, ultrasound, MRI or CT scan)? **YES** ☐ **NO** ☐
If yes please list what scan, where it was taken and when (date) so we can request them.

Have you had NHS physiotherapy for this complaint, has it helped? **YES** ☐ **NO** ☐

What diagnosis have you been given to date for your complaint? _____

Have you seen any other therapist for your pain (Chiropractor, osteopath, sports therapist, acupuncturist, massage therapist, bowen etc) if yes please list who you have seen and any diagnosis/treatment given. **YES** ☐ **NO** ☐

Therapist: _____

Treatment: _____

Have you received any other medical treatment for any other health condition recently? Please list:

Details: _____

Please list any medication you currently take below:

## ACCIDENT OR TRAUMA

Have you had any accident to cause this condition? If yes please explain: **YES** ☐ **NO** ☐

Have you had any other injuries or physical trauma in your life that might be relevant?
(broken bones, ligament, cartilage or soft tissue damage) If yes please list: **YES** ☐ **NO** ☐

Have you had any road traffic accident (even minor)? **YES** ☐ **NO** ☐

Details: _____

HAVE YOU OR ANY FAMILY MEMBER, SUFFERED WITH PROBLEMS IN ANY OF THE FOLLOWING AREAS:

| | SELF | IMMEDIATE FAMILY | YEAR |
|---|---|---|---|
| Liver/kidney problem | | | |
| Heart/stroke problem | | | |
| Lung/breathing problem | | | |
| Digestion problem | | | |
| Bowel problem | | | |
| Bladder problem | | | |
| Reproductive problem | | | |
| Circulation problem | | | |
| Diabetes | | | |
| Cancer | | | |
| Epilepsy/nervous disorder | | | |
| Allergy/skin disorder | | | |
| Blood pressure problems | | | |
| Migraines/headaches | | | |
| Dizziness | | | |
| Tinnitus (buzzing in ears) | | | |
| Ears/eyes/nose/throat problems | | | |
| Arthritis/orthopaedic problems | | | |
| Neurological disorder | | | |
| Endocrine disorder (thyroid, parathyroid) | | | |
| Mental health problem (anxiety/depression) *Please list what* | | | |

## CONSENT POLICY AND WRITTEN CONSENT

The Sykes Verwey Chiropractic Centre endeavours to respect your privacy and security of your personal information and our GDPR compliant. All your personal details and information are only accessible by the reception staff and the Chiropractor. All information is maintained securely and cannot be breached. Your details will not be shared without your consent. *If you would like to read a full copy of our privacy policy please ask a member of staff.*

**Be confident in the knowledge that your personal information we hold about you is:**

- Processed fairly, lawfully and in a clear, transparent way
- Collected only for valid reasons that we find proper for the course of your time as a patient and not used in any way that is incompatible with those purposes
- Only used in the way that we have told you about
- Accurate and up to date
- Kept only as long as is necessary (8 years)
- Processed it in a way that ensures it will not be used for anything that you are now aware of or have consented to
- Kept securely

Please mark that you have read, understand and our happy with our privacy policy.

**YES** ☐ **NO** ☐

## CONSENT FORM

IN THE INTEREST OF LEGITIMATE INTEREST REGARDING YOUR CARE:

Do you give your consent to a letter being sent to your GP if required? **YES** ☐ **NO** ☐

Do you consent to being contacted to confirm your appointments with us or to update you on matters relating to your Chiropractic treatment. **YES** ☐ **NO** ☐

Do you consent to receiving general health information in the form of articles, advice or newsletters. You may withdraw this consent at any time, please let us know by any convenient method you prefer. **YES** ☐ **NO** ☐

## CONSENT TO EXAMINATION

During the consultation your chiropractor will need to perform various orthopaedic, neurological and chiropractic tests together with a physical examination of your problem area in order to establish whether we can help you or not.

Do you consent to this examination? **YES** ☐ **NO** ☐

## CONSENT TO TREATMENT ( To be signed by yourself AFTER the consultation)

I have been given a copy and read through the pamphlet "Your First Visit To A Chiropractor".
I have understood everything in regards to my complaint and have had my diagnosis explained to me clearly.
I have had a treatment plan outlined, and the Chiropractor explained what the treatment will entail and any possible risks associated. I have had all my questions answered to my satisfaction.
I consent to the treatment as it was outlined to me.

☐ DIAGNOSIS

☐ TREATMENT PLAN ☐ Acute Injury < 3months - 4 treatments ☐ Chronic Injury > 3months - 8 treatments

☐ PROGNOSIS **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent** ☐

☐ RISK FACTORS Common symptoms: post treatment soreness (DOMS), lightheadedness, skin redness, tiredness.

Signed: _____ Dated: _____

If you are under 16 years of age, this consent should be signed by a parent of legal guardian.

Name: _____ (PLEASE PRINT)