Case No

Date

DC

Orchard Chiropractic Centre
Introductory Form

Surname: Forename: Title:

Date of Birth: Age:

Full Address:

Home tel: Work tel: Mobile:

Email Address:

Marital status: Number/ages children:

Occupation: Previous occupation/s:

Name/Address and Tel of GP:

Recommended/referred by: Medical Insurance Company:

Medical History

Do you/ have you suffered from problems with any of the following? (please tick, details asked later)

- ☐ eye/vision
- ☐ ear/hearing
- ☐ nose bleeds/nasal obstruction
- ☐ facial pain
- ☐ encephalitis/meningitis
- ☐ indigestion/heartburn
- ☐ vomiting/nausea
- ☐ irritable bowel symptoms
- ☐ haemorrhoids
- ☐ skin problems
- ☐ lung/breathing
- ☐ asthma
- ☐ TB
- ☐ sore throats
- ☐ sinus
- ☐ diabetes
- ☐ gall stones/ jaundice
- ☐ kidney/bladder
- ☐ prostate
- ☐ epilepsy
- ☐ high/low blood pressure
- ☐ heart disease
- ☐ chest pain/palpitations
- ☐ stroke
- ☐ fainting/dizziness
- ☐ allergies
- ☐ joint pain/swelling
- ☐ loss of weight/ energy
- ☐ sleep disturbance
- ☐ cancer

Please list any medication being taken at present or recently

Please give details if you have…

…broken any bones?

…had any accidents eg. car / sports / falls?

…ever had major medical treatment / tests / surgery?

Do you consider yourself to be in good health?

Do you consider yourself to be under stress? financial / work / relationship / family

Is there anything else you feel you should mention about your health?

Dental History

Name/address of dentist:

Do you…

- ☐ ...suffer with jaw pain / clicky jaw / lock jaw?
- ☐ ...grind your teeth?
- ☐ ...wear a dental appliance/dentures?

Have you…

- ☐ ...worn an orthodontic brace?
- ☐ ...had dental surgery?
- ☐ ...had any permanent teeth removed?

Reason for today's visit

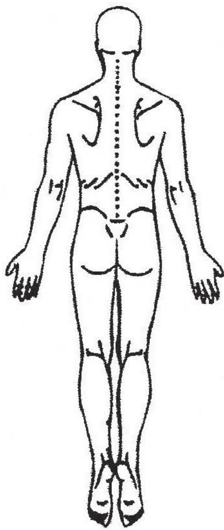
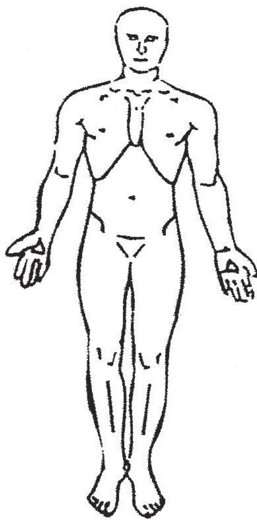
What symptoms, if any, do you have?

Any tests/diagnosis/treatment for present complaints?

If you are experiencing discomfort, where on a scale of 0-10 would you rate it? X at worst O at best

0 1 2 3 4 5 6 7 8 9 10

Please indicate where you have a complaint/s:

Have you received Chiropractic care before? Where and when?

Are you looking for:

Just pain relief? Pain relief and optimum corrective care? Maintaining your health after this episode?

Data protection

It is a requirement of data protection that we have written permission from you to allow us to communicate with other professionals involved in your health care. Please sign below if you are happy for us to do this.

Signed .... Date ....