CompleteHealth
CHIROPRACTIC - PHYSIOTHERAPY - MASSAGE

WELCOME

Physiotherapy Patient Information

Name _____ Date of Birth _____

Address _____ Post code _____

Home phone _____ Work phone _____ Mobile _____

Occupation _____ Email _____

Status (please tick): ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children _____ Ages _____

Private Insurance Co. _____ Will you be claiming insurance? (Please tick) ☐ Yes ☐ No

Reason for consultation: _____

Whom may we thank for referring you to our clinic? _____

Your Health Profile

Why This Form Is Important

As a wellness based multi-disciplinary clinic, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to us, and second to offer you the opportunity of improved health potential in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Early Years (to age 16)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years	**Yes**	**No**
Did you have any serious falls or physical traumas as a child?	☐	☐
Did you play youth sports?	☐	☐
Did you have any surgery?	☐	☐
Any prolonged use of medicines such as antibiotics or an inhaler?	☐	☐

Comments: _____

_____

Adult (18 to present)	**Yes**	**No**
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐
Do/did you take any medications/drugs?	☐	☐
Do/did you play any adult sports?	☐	☐

On a scale of 1 to 10 describe your stress level: (1 = none, 10 = extreme)

Occupational _____ Personal _____

On a scale of Poor, Good or Excellent, please rate your:

Diet: _____ Exercise: _____ Sleep: _____ General health: _____

On a scale of 0-10 (10 being Excellent), rate your quality of life: _____

Addressing the issues that brought you to this office

Chief complaint and cause _____

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Intermittent (comes & goes) ☐ Constant

How long have you been experiencing this problem? _____

Since the problem has started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? _____

Indicate what your present condition is affecting: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Rate your level of pain (please circle): No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Other Doctors seen for this problem (please list):

Chiropractor: _____ Medical Doctor: _____

Other: _____

Health Profile

Please tick all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches
☐ Migraines
☐ Neck Pain
☐ Mid back pain
☐ Low back pain
☐ Shoulder pain
☐ Arm/wrist pain
☐ Hip pain
☐ Leg pain
☐ Knee/Ankle pain
☐ Pins & Needles
☐ Arthritis

☐ Morning stiffness
☐ Fatigue
☐ Dizziness
☐ Fainting
☐ Ringing in ears
☐ Heart trouble
☐ High blood pressure
☐ Poor circulation
☐ Palpitations
☐ Chest pain
☐ Liver problems
☐ Asthma

☐ Breathing problems
☐ Blurred vision
☐ Indigestion
☐ Constipation
☐ Kidney problem
☐ Bladder problems
☐ Prostate trouble
☐ Diabetes
☐ Allergies
☐ Hot sweats
☐ Cancer

☐ Sleep problems
☐ Depression
☐ Panic Attacks
☐ Other:
_____

Women Only
☐ Hot Flushes / Night sweats
☐ Heavy menstruation
☐ Painful menstruation
☐ Irregular cycle

For Women Only (we require the following information)
Date of your last period if known: ……
Is there any possibility of you being pregnant? (please tick) ☐ Yes ☐ No

GDPR

We reserve the right to contact you via post, email, text message or phone in relation to appointment reminders, requests and other aspects of your care.

Please tick the box to give consent for Complete Health to contact you as per the methods stated above. ☐

I hereby consent to this information and any subsequent information pertaining to my examination and treatment to be retained and stored by this clinic (Complete Health Eastbourne). In accordance with the clinic privacy policy and the General Data Protection Regulation (GDPR)(EU) 2016/679.

The statements made on this form are accurate to the best of my recollection. I allow this office to examine me for further evaluation. I also agree that any x-rays taken by this clinic are an important part of the patient's permanent records and as such remain the property of the clinic.

Client signature……Date……

Parent or guardian (if client is under 16 years old) ……

Client Name_____ Client DOB_____ Client No_____

Current Health:

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Past Health:

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Family Health:

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Trauma History (RTA, Surgery, Physical, Emotional):

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Lifestyle (Diet, Sleep, Exercise, Work, Meds):

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History of investigation (Imaging, Bloods, Health Screening):

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Clinical Impression:

Complaint: ……

Trauma ( ) None ( ) Present

Related to complaint: ( ) No ( ) Directly ( ) Indirectly ……..

Significant Findings: ……..

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Red Flags: ( ) None ( ) Present……..

Further Investigation: ( ) not indicated ( ) Indicated ……..

Reasons: ……..

Findings: ……...

Chiropractic adjustments: ( ) Not Indicated ( ) Indicated

Recommendations

Impression: ……

Areas of adjustments: ( ) Full Spine ( ) Cx ( ) Tx ( ) Lx ( ) Pelvis ( ) Extremity

Schedule of Care: ……