New Patient Information Form

Surname.....**Mr, Mrs, Ms, Miss, Dr, Other** .....**Age**.....

Forenames.....**Date of Birth**.....

Full Address.....

.....**Post Code**.....

Marital Status.....**Number and Age of Children**.....

Contact Number (Home)..... **(Work)**.....

(Mobile)..... **Email Address** .....

How did you hear about the clinic?.....

EMPLOYMENT DETAILS

Occupation.....**Number of years in current job?**.....

What does your job involve (e.g. sitting, lifting)?.....

HEALTH DETAILS

Name of GP.....**GP Surgery**.....

Current Medication.....

Relevant Past Medical History.....

Are you currently exercising? Provide details:.....

Any previous Operations/Hospitalisation: (Date/Year).....

Previous X-Ray/CT/MRI (Date/Year).....

Do you smoke?.....**per day and for how long**..... **Do you drink?**.....**No of units per week**.....

Have you consulted your GP about any other conditions recently? YES/NO

Details:.....

.....

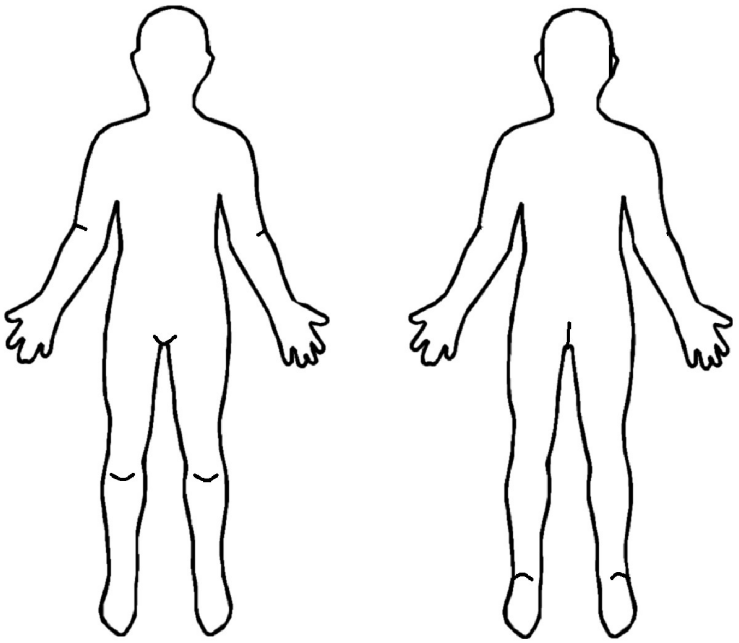
Are you currently receiving treatment for your this or another complaint with any other health care provider?.....

What was the outcome/progress so far of that treatment?.....

.....

Please indicate if you, or any family member, suffered with problems in any of the following areas:

Heart/circulation/blood pressure		Eyes	
Stroke		Migraines/headaches	
Respiratory (breathing/lungs)		Joints	
Digestive system		Mental state	
Bowels		Weight	
Urinary tract (kidneys, bladder, etc)		Pregnancy	
Reproductive system		Cancer	
Liver and gall bladder		Nervous system (e.g. MS, epilepsy)	
Ears/Nose/Throat		Skin	
Diabetes		Osteoporosis	



Please shade the area where you are experiencing symptoms using the key provided below

Key
Pain - XXXX
Stiffness - ////
Numbness – OOOO
Other (specify) - ____

How severe are your symptoms?	**Please indicate the severity of your symptoms (Barely noticeable = 1 to Maximum = 10)**
Severity at onset?	
Current level?	
Maximal experienced?	

Please circle the appropriate answer:

Have you had a similar episode in the past?	☐ Never ☐ Within the last year ☐ Over a year ago
How long have you been experiencing these symptoms?	☐ 0 - 4 weeks ☐ 4 to 12 weeks ☐ 12 weeks to one year ☐ Over one year


LC Clinic