Confidental Health Questionnaire

WINCHESTER SPINE CENTRE
BACK PAIN NECK PAIN SPORTS INJURIES

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Married: _____ Children: _____

Full Name: _____ Date of Birth: _____

Home Address: _____ Occupation: _____

_____ Telephone Numbers

Post Code: _____ Home: _____

GP Name and Surgery: _____ Work: _____

_____ Mobile: _____

_____ Email: _____

How did you hear about the clinic?

Web Search ☐ Family/Friend ☐ Sign Outside ☐ GP ☐ Other ☐

Present Complaint? _____ **Date of Onset?** _____

What is your present condition preventing you from doing or enjoying?

_____

What would represent a successful outcome to your treatment?

_____

What Makes it worse? _____

What Makes it Better? _____

Have you had a diagnois? If so, from whom and what treatment was given?

_____

Have you ever suffered from any of the following? Please tick if appropriate

Asthma	☐	Heart Disease	☐	Allergies	☐	Pleurisy	☐
Angina	☐	Eczema	☐	Hiatus Hernia	☐	Pneumonia	☐
Appendicitis	☐	Encephalitis	☐	HIV	☐	Polio	☐
Alcoholism	☐	Epilepsy	☐	Jaundice	☐	Prostate	☐
Arthritis	☐	Gall Stones	☐	Kidney Stones	☐	Rheumatic Fever	☐
Cancer	☐	Glandular Fever	☐	Meningitis	☐	Tuberculosis	☐
Diabetes	☐	Goitre	☐	Mental Illness	☐		

Dental history. Please tick if appropriate

Have Jaw Pain	☐	Clicking Jaw	☐	Locking Jaw	☐	Nocturnal Grinding	☐
Wear Dentures	☐	Orthodontic Treatment	☐	Orthodontic Surgery	☐		

Nutrition

How many cups or glasses of Water _____ Tea/Coffee _____ do you drink each day?

Is there any advice you'd give yourself, or that you would like to receive about your eating habits _____

_____

_____

What exercise do you do? Tick as appropriate

Gym ☐ Pilates/Yoga ☐ Run ☐ Cycle/Spin ☐ Exercise class ☐ Walk ☐ Other ☐

Indicate the amount/frequency of your exercise and if a gym goer, who devised your program and when?

_____

Do you regularly suffer from any of the following? Please tick if appropriate

Headache	☐	Migraines	☐	Convulsions	☐	Dizziness	☐
Fainting	☐	Sinus Infection	☐	Deteriorating Vision	☐	Hayfever	☐
Nose Bleeds	☐	Frequent Colds	☐	Earache	☐	Loss of Weight	☐
Eye Pain	☐	Eye Squint	☐	Bronchitis	☐	Ear Discharge	☐
Loss of Energy	☐	Deafness	☐	Chest Pains	☐	High Blood Pressure	☐
Ear Noises	☐	Facial Pain	☐	Ulcers	☐	Nausea	☐
Palipitations	☐	Difficulty Breathing	☐	Heartburn	☐	Bowel Problems	☐
Low Blood Pressure	☐	Kidney Infection	☐	Poor Appetite	☐	Bloating/Gas	☐
Swollen Joints	☐	Indigestion	☐	Poor Bladder Control	☐	Skin Problems	☐
Constipation	☐	Diarrhoea	☐	Sexual Impotency	☐	Loss of Sleep	☐
Blood in Urine	☐	Frequent Urination	☐	Bedwetting	☐	Do You Smoke	☐

We sometimes see a link between lifestyle factors and symptoms. Do you feel any of the following may be contributing to how you are feeling and are you open to looking at these areas?

Posture at Work ☐ Stress ☐ Exercise Habits ☐ Eating Habits ☐

Please answer the following, giving details and dates

Have you had any surgery? _____

Have you ever broken any bones? _____

Have you had any accidents, e.g. vehicle/sports injuries/falls? _____

Have you ever had any major treatments, tests or x-rays? _____

Are you currently attending hospital or seeing a medical doctor? _____

How many hours sleep do you get per night? _____

Have you ever received chiropractic care, where and when? _____

FOR WOMEN ONLY

Painful Periods	☐	Discharge	☐	Hot Flushes	☐	PMT	☐
Irregular Periods	☐	Cystitis	☐	Miscarriage	☐	Menopause	☐
Excessive Flow	☐	Thrush	☐	Cannot Conceive	☐	Contraceptive Pill	☐

Date of the onset of your last period _____ To the best of your knowledge are you pregnant? Yes ☐ No ☐

I do ☐ **I do not** ☐ **consent to the communication of all relevant information about my complaint to my doctor.** (Please tick appropriate box)

Please sign: _____ Date: _____