1

**Admin use**
Entered Computer

**Assessment Date**

**Your Osteopath Today is: Carl Georgia Melvin**

## Intake Questionnaire "Ensuring we understand as much about your health and well-being as you do"

To ensure that our information is accurate we request that you complete the following which will also serve as consent to treatment terms. All information will be treated with the appropriate confidentiality .

## Our Professional Fees : Initial Consultation & Treatment £50.00 : Subsequent Treatments per visit £36.00 : Children and Students Consultation /Treatment £30.00

**Your Contact Details:**

**Title Mr/Mrs/Miss/Ms/Other:**

**First Name:**.....

**Surname:**.....

**Address:**.....

.....

.....

**Postal Code**:.....

**Home Tel.**:.....

**Work Tel.**:.....

**Mobile:**.....

**E-mail**:.....

**Date of Birth:** ...../...../.....

**Occupation**:.....

**Are you** :- Single/ With Partner / Married/ Divorced /Widow ?

**How did you find out about us?** Friend /Family / Internet / Yellow Pages/ Doctor/ Other

**General Practitioner Surgery?**.....

**Do you know Your Height?** **Weight ?**

**Hobbies?**
.....

**What Sports/ Exercise (Active) ?**.....

**If you are an Medical Insurance Patient Please Complete the Details below**

Insurance Company.....

Authorisation Number..... Any Excess?.....

**YOUR CURRENT MEDICAL HISTORY Do you suffer from or have you been diagnosed with any of the following?**

| Yes | No | If YES, Please give Brief details: |
|---|---|---|
| ○ | ○ | **A.** Are you taking any Regular Prescribed Medications or Over The Counter Medications you are using for whatever reason ? Could You Please list them? |
| ○ | ○ | **B.** Diabetes? If yes, please indicate: IDDM (type I) NIDDM (type II) |
| ○ | ○ | **C.** High Blood Pressure (HBP)? If high, are you taking Diuretics, Anti-Hypertensive's or Beta-Blockers? |
| ○ | ○ | **D.** Heart/ Circulation Problems? Angina / Palpitations / Varicose veins, /Thrombosis |
| ○ | ○ | **E.** Epilepsy? If yes, have your seizures been stabilised on Medication? Yes No |
| ○ | ○ | **F.** Asthma or other breathing problems? Bronchitis ? Do you suffer from shortness of breath/dizziness during exercise? |
| ○ | ○ | **G.** Have you been diagnosed with Osteoporosis? Please Circle Yes No |
| ○ | ○ | **H.** Do you have any Joint Replacements? Hips /Knees/Shoulders |
| ○ | ○ | **I.** Do you suffer from Digestive Complaints (Indigestion, Ulcers, Reflux, Colitis etc)? |
| ○ | ○ | **J.** Have you noticed any Bowel or Bladder changes recently Blood or Pain Passing Stools? Urgency/leaking /increased urination ? |
| ○ | ○ | **K. Have you been diagnosed with any form of Cancer? If so please underline any of the following Full/Partial Mastectomy / Reconstruction / Chemotherapy / Radiotherapy / Hormonal Therapy** |

2.

## This Section applies to Ladies only : Gynaecological

Yes No

1. **Are you or could you be Pregnant now?**
   If yes, when is your due date? _____
2. Have you had any previous pregnancies?
   Please list delivery year(s):
3. Previous delivery methods: Natural ○ Caesarean ○ Assisted ○ Forceps ○ Episiotomy ○
4. Your Menstrual Cycle: Regular ○ Irregular ○ PMT ○ Amenorrhoea ○ Endometriosis ○
5. Are you Post Menopausal or had a Hysterectomy ? How old when periods finished?

## YOUR PAST MEDICAL AND INJURY

Yes No **Where applicable please provide brief explanations below**

**A. Have you been involved in Any Major Accident(s) (e.g. Motor Vehicle Accidents? Or Falls** ? _____

**B. Have you had any Major Operations e.g. Tonsils Appendix, Gall Bladder Hysterectomy Moles etc anything requiring Anaesthetic?**

_____

**C. Have you had any Broken Bones or stress fracture? If yes, do you currently have any metal plates/pins or screws in place?**

_____

D. **Are you Allergic to anything Drugs: Pollen : Foods Mites Dust or Stings etc?**

_____

**E. Have you had any foot or ankle problems/injuries?**

_____

**F. Have you had any knee or hip problems/injuries?**

_____

**G. Have you had any shoulder/elbow or wrist problems/injuries?**

_____

**H. Have you had any other muscle/ligament or tendon problems/injuries?**

_____

**I. Have you had any neck problems/injuries (e.g. Whiplash)? If so please indicate the date:**

_____

**J. Have you had any low back problems/injuries? If so please indicate the number of previous episodes:**

_____

**K. Are you currently off work due to pain or disability? If yes, how long have you been off?**

_____

**L. Have you been diagnosed as hypermobile (excessive joint mobility)**

**I. Is there any other longstanding Medical Condition or Disability not already covered**

_____

_____

_____

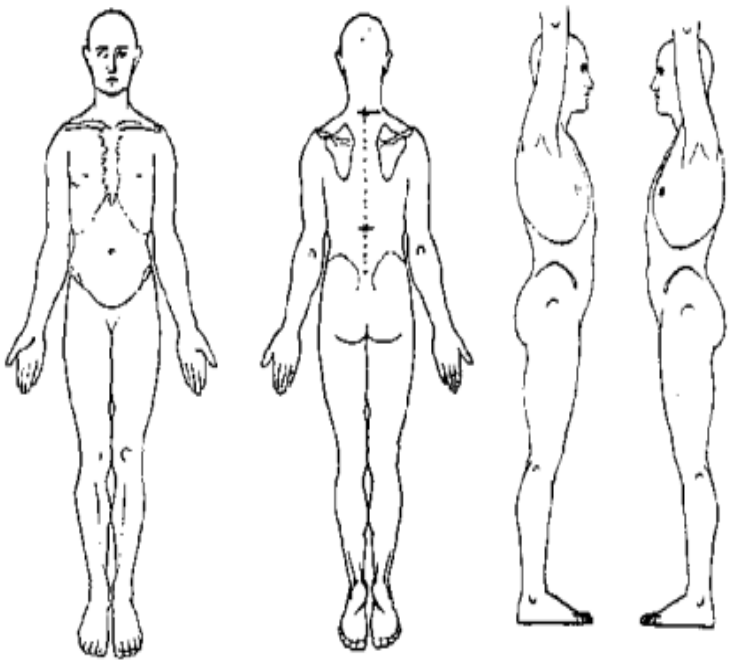
**Where is Your Pain ?**

1. Please Circle on the drawing - The areas where you feel Pain or Discomfort

2. Mark the Most Painful Spot with an "X"

3. Use Arrows to Show where Pain goes (Radiates)

Initial Onset Sudden ◯ ◯ Gradual



Y N

**ADDITIONAL RELEVANT INFORMATION**

**A. Have you had any Recent Investigations (X-ray/MRI-scans or Blood Tests)?**

B. Eating Habits ? Regular Meals / Vegetarian / Vegan / Special Diet? ( Please circle)

C. Does any ill health run in the family? ( Heart disease, Cancer, Diabetes, Stroke, Neurological)

D. General Health - How are you compared to 100% able to relax and sleep _____%

E. Have you ever smoked? If Smoker How many/much a Day? ____When did you Give up?_____

F. Weekly units of Alcohol Beer/Wine/ Spirits _____ 1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits)

**Treatment is undertaken by mutual understanding of the aims of treatment that will be explained by your Osteopath . All relevant information related to the injury or condition is to be given during the initial assessment.**

**Patients Responsibility**

1. Consent for treatment is the responsibility of the patient, but correspondence with GP or referring Consultant/ Insurance company may be necessary with prior agreement
2. If you are Insured Check the terms of your insurance policy and advise any excess details.
3. Pay for your treatment, at the end of each visit.
4. I undertake to pay fees which are charged at the Clinic's standard rates for Consultation and treatments .
5. I acknowledge that payment for treatment is my responsibility as are claims made to insurance companies. If there is an excess on my policy I agree to pay this direct to the Jessup Clinic .
6. If I miss an appointment a DNA charge may be levied.

**Consent to Treatment**

7. I confirm that the information I have provided in this form and during the course of my treatment is, to the best of my knowledge accurate and the explanation that will be given to me will form the basis of my consent for Osteopathic Treatment and Examination. **Additionally,** I understand that I may tell the practitioner to STOP at ANY STAGE, if I am unhappy with any aspect of the examination or treatment

**Signed:** **Date:** ***Thank you***