Your Osteopath Today is Carl Emma

Exercise?

Urine Leaking / Increased Urination?

Radiotherapy / Operation



Intake Questionnaire 2024

We would like to welcome you to our Practice. Please complete this form in as much detail as you can. This will not only help your Osteopath understand your total state of health, it can help us discover any medical conditions that may need referral to your Doctor.

		us discover any medical conditions that m	ay need referral to your Doctor.					
You	r Co	ntact Details						
Title	Mr /N	Mrs/Miss/Ms/Other (Circle)	Occupation					
First	Nam	nes:						
		······································	Occupation					
			GP Surgery					
		Post Code	Height Weight					
Mob	ile Nı	umber	Active Exercise?					
		ephone	Hobbies?					
Worl	k Tele	ephone						
			CompanyExcess Yes/No					
Date	OID	irth/	Authorisation					
Yes No Your Current Medical History - If you Suffer or have been Diagnosed wifellowing - Please Tick Yes / No / & Circle if appropriate.								
	Your Current Medical History - If you Suffer or have been Diagnosed with any of the following - Please Tick Yes / No / & Circle if appropriate. Are You taking any Regular Prescribed Medications? or Over the Counter Medications? County you please list them:-							
		Diabetes? If yes, IDDM Type I NIDDM Type II						
		High Blood Pressure / Heart/ Angina/ Palpitations/Thrombosis ?						
		Circulation / Night Sweats / Varicose Veins / Stroke/ TIA ? (Recent unexplained Weight Loss or Gain)						
		Thyroid (Underactive) or (Overactive)?						
		Epilepsy ? If Yes have your Seizures Stabilised on Medication ? Yes No						
		Have you been Diagnosed with Osteoporo	with Osteoporosis or Osteopenia?					
		Joint Replacements:- Hips / Knees / Other	?.					

Asthma / Bronchitis/ COPD/ Other Breathing Problems / Shortness of Breath / Dizziness on

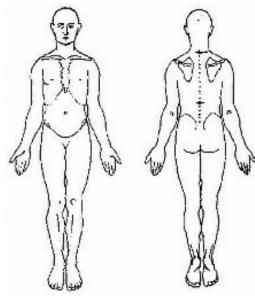
Have you noticed any Bowel or Bladder changes recently e.g. Blood or Pain passing stools /

Any Form of Cancer? If so please circle any of the following if appropriate Chemotherapy /

Digestive Complaints:- (Ulcers / Reflux / Indigestion / IBS / Colitis etc?)

Yes	No	This Section Applies to Ladies Only - Gynaecological					
		Are You or Could you be Pregnant Now? If Yes What is your Due Date?					
		Have you had any Previous Pregnancy's? Please list Delivery year(s):-					
		Previous Delivery Methods: Circle Natural Caesarean Assisted Forceps Episiotomy					
		Your Menstrual Cycle Please Circle Regular Irregular Amenorrhea Endometriosis					
		Are you Post Menopausal / Menopausal Sweats / Age Periods finished? Hysterectomy?					
		Have you had a Mammogram? If yes what were results?					

Yes	No	Your Past Medical and Injury History - Where Appropriate Circle or give Brief Explanations.
		Have you been involved in any Major Accidents e.g Motor Vehicle /Falls?
		Any Major Operations Tonsils Appendix Gall Bladder Hysterectomy Moles etc . Any Op requiring Anaesthetic?
		Any Fractures Broken bones/Stress fractures. Do you currently have any pins or plates in place?
		Allergic to Anything e.g. Drugs / Pollen / Dust / Animals
		Any Foot or Ankle Problems/Injuries?
		Have you had any Knee or Hip problems/injuries?
		Any Shoulder/Elbow or Wrist /Hand Problems/Injuries?
		Any other Muscle/Ligament or Tendon problems/injuries?
		Any Neck problems/injuries (e.g. Whiplash)? If so please indicate Year:
		Any Low Back problems/injuries? If so please indicate the number of previous episodes:
		0-5 6-10 11+ Date of Most Recent Episode?
		Are you currently off Work due to Pain or Disability? If yes,, how long have you been off?
		Have you been diagnosed as Hypermobile (Excessive Joint Mobility)
		Is there any other longstanding Medical Condition or Disability in your past not already covered above that your Osteopath should be aware of? E.g. Thyroid /Kidney/ ME / Pneumonia / Haemophilia/ Hiatus Hernia / MS / Fibromyalgia / Rheumatic Fever
		Migraines or Headaches? Circle Which Type? Tension / Sinusitis / Cluster/ MIGRAINE
		Do any of your family (Parents/Grandparents) have any of the following TB / Epilepsy / Asthma/ Heart/ Circulation problems/ Cancer/ Diabetes/ Glaucoma



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 (spreads or radiates)
- **4.VAS** Pain Scale Please mark the discomfort you are in today 0 -10 No pain 0 5 Severe Pain 10
- 5. Frequency: Please Circle Constant Intermittent Occasional
- **6**.. Did the Pain/Discomfort come on **immediately** or did it develop over **hours or days**?
- **7. Please Shade in areas if you have any of the following :-** Pins or Needles **0000000**, Numbness :::::::::: Loss of Sensation ?
- **8**. Have you already seen a Doctor or Specialist or Therapist for this condition **Yes** / **No**
- 9. Have you had a similar episode in the past Yes / No

Yes	No	ADDITIONAL RELEVANT INFORMATION Please Tick or Circle					
		Have you had any Recent Investigations (X-Ray/CT/MRI-Scans or Blood Tests? Results Known?					
		Eating Habits ? Regular Meals / Vegetarian / Vegan / Gluten Free / Special Diet? (Please circle)					
		Have you ever Smoked/Vaped? If Smoker How many/much a Day? Vape Ex Smoker what Year did you Give up?					
		How Much Alcohol do you drink in an average week? Approximate Wine/ Beer / Spirits?Glasses / Units					
		Do you consider yourself under Stress? Mild Moderate Severe Home / Work					

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

I consent to you creating and storing medical records concerning my treatment which may include details concerning my medication, treatment and other issues affecting my health conditions in accordance with the General Data Protection Regulation. I understand that these records will be processed in accordance with our 2019 GDPR policy. I agree to the use of SMS /Email/ Telephone/ Post to remind me of appointments etc.

If I miss an appointment a DNA charge of £25,00 may be levied.

Please remember that your body will have undergone some change from any treatment today, causing some biochemical and physiological change, that may be felt as soreness or stiffness. This is entirely an individual process that might be most marked for **24-48 hours** after your initial treatment, if you have concerns please ring

We accept Credit/Debit Cards) Cash and Cheque's. Please settle your fees after each session.

Professional Fees From 1st March 2024 Initial Consultation with Treatment £60.00 Subsequent Treatments £42.00

Children and Students Under Age 18 - Initial Consultation £55.00 Subsequent Treatments £40.00

	have read	and	understood	the a	bove in	formation.	Signed:
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