Admin Entered **Date**

Your Osteopath Today is **Carl** **Emma**

Jessup Osteopathic Clinic

Intake Questionnaire 2022

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.

Your Contact Details

Title Mr /Mrs/Miss/Ms/Other (Circle)

First Names:-……

Surname:……

Address:……

……

……Post Code……

Mobile Number……

Home Telephone……..

Work Telephone……

Email ……

Date of Birth……../……../……

Occupation……..

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

How did you find out about Us? Friend/Family/ Website/ Facebook/ Doctor/ Other ?

GP Surgery……

Height…….. Weight ……

Active Exercise?……

Hobbies?……

If you have Private Medical Insurance - Your Authorisation Details for Carl Jessup Osteopath:-

Company……..**Excess Yes/No**

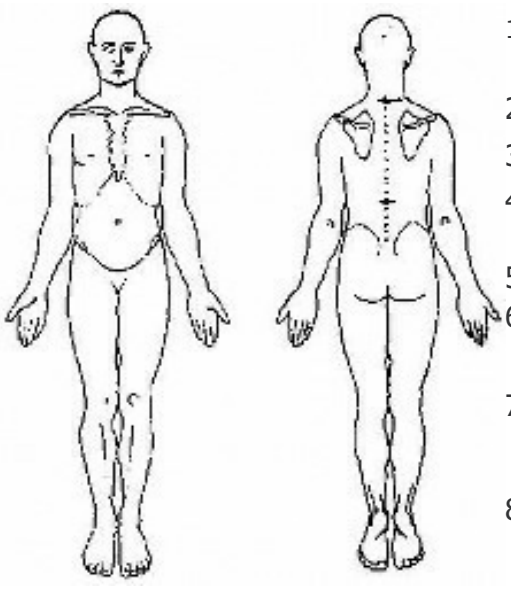
Authorisation……..

Yes	No	**Your Current Medical History - If you Suffer or have been Diagnosed with any of the following - Please Tick Yes / No / Circle**
		Are You taking any Regular Prescribed Medications? or Over the Counter Medications ? Could you please list them:-
		Diabetes? If Yes Please Circle IDDM Type I NIDDM Type II
		High Blood Pressure / Heart/ Angina/ Palpitations ?
		Circulation / Night Sweats / Varicose Veins / Hepatitis/ Thrombosis/ Stroke/ TIA ?
		Thyroid (Underactive) or (Overactive)?
		Epilepsy ? If Yes when was your last Seizure:-
		Osteoporosis?
		Joint Replacements:- Hips /Knees /Shoulder / Other ?
		Asthma/ Bronchitis/ COPD/ Other Breathing problems?
		Digestive Complaints:- Ulcers / Reflux/ Indigestion / IBS /Colitis etc?
		Have you noticed any Bowel or Bladder changes recently e.g. Blood or Pain passing stools / Urine Leaking / Increased Urination ?
		Any Form of Cancer? If so please circle any of the following if appropriate Chemotherapy / Radiotherapy / Operation

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 year(s)
		Previous Delivery Methods: Circle Natural Caesarean Assisted Forceps Episiotomy
		Your Menstrual Cycle Please Circle Natural Irregular Amenorrhea Endometriosis
		Are you Post Menopausal /Had Hysterectomy ? Age Periods finished
		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? Year?
		Any Major Operations Tonsils Appendix Gall Bladder Hysterectomy Moles etc . Any Op requiring Anaesthetic? Year?
		Any Fractures Broken bones/Stress fractures 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 Last 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 Serious illness in your past ? Rheumatic fever or longstanding medical condition or disability e.g. Thyroid /Kidney/ ME / Rhuematic Fever / TB / Glandular Fever / Pneumonia /Haemophilia / Bruising / Lost or Gained Weight for no Apparent Reason - not already covered above?
		Migraines or History of Headaches?
		Do any of your family (Parents/Grandparents) have any of the following TB / Epilepsy / Asthma/ Heart/ Circulation problems/ Cancer/ Diabetes/ Glaucoma ?

About 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 indicate in areas if you have any of the following :-**
   Pins or Needles (00), Numbness (N) Loss of Sensation (S) ?
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?
		Eating Habits ? Regular Meals / Vegetarian / Vegan / Special Diet? (Please circle)
		Have you ever Smoked/Vaped? If Smoker How many/much a Day? ____ Vape _____ Ex Smoker When did you Give up?
		How Much Alcohol do you drink in an average week? Approximate number of glasses Wine/ Beer / Spirits? ……..Glasses
		Do you consider yourself under stress? Mild Moderate Severe :: **Circle** 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 personal data about me during and after my time as patient of this Clinic 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**.**

In the case of treatment to a minor or a person who is recognised to have diminished intellectual capacity this consent is to be signed by a parent or legal guardian

II understand that if I miss an appointment a charge of £18,00 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,
We accept Credit/Debit Cards (Not American Express) Cash and Cheque's. **Please settle your fees after each session.**

Osteopath Professional Fees :-

Initial Consultation with Treatment **£50.00**
Subsequent Treatments **£38.00**

Children and Students Under Age 18 - Initial Consultation **£40.00**
Subsequent Treatments **£35.00**

I have read and understood the above information and give my consent. **Signature** **Date:**