1 **Admin use**
Entered Computer

Assessment Date

Your Osteopath Today is: Carl Georgia Melvin

Intake Questionnaire 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, but can help us discover any medical conditions that may need referral to your doctor.

Our current Professional Fees are

1st Consultation and Treatment £50.00 Subsequent Treatments £36.00 per visit

Children and Students £30.00 per visit

Your Contact Details:

Title Mr/Mrs/Miss/Ms/Other(please state)

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 / Widower ?

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

Doctor or Name of Surgery?.....

Do you know Your Height? Weight ?

Hobbies? .....

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

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

Insurance Company..... 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 History

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: Please Circle - Natural Caesarean Assisted Forceps Episiotomy
4. Your Menstrual Cycle: Please circle Regular Irregular PMT Amenorrhea Endometriosis

5. Are you Post Menopausal or had a Hysterectomy ? How old when periods finished?
6. Have you had a mammogram ? If yes how long ago? What were the results?

YOUR PAST MEDICAL AND INJURY HISTORY

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

A. Have you been involved in Any Major Accident(s) (e.g. Motor Vehicle Accidents/Fall?)

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:

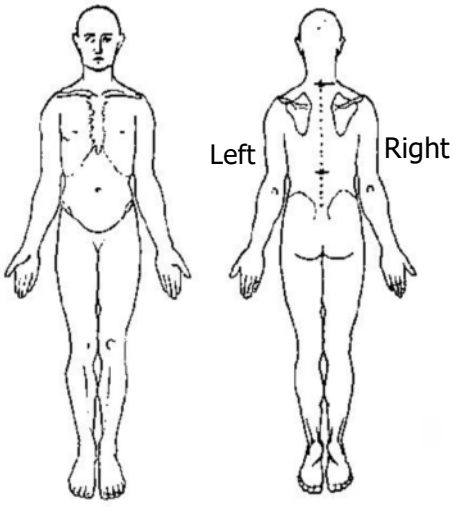
0-5 6-10 11+ most recent episode, date: _____

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)

M. Is there any other Serious illness in your past ? rhuematic fever/ migraine or longstanding medical condition or disability e.g. Thyroid /kidney/ ME not already covered above?

N. 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 top the Left - **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)

VAS Pain Scale please mark the discomfort you are in today 0 -10

No pain 0 5 severe pain 10

Frequency: Please circle **Constant Intermittent Occasional**

Did the Pain come on immediately or did it develop over hours or days

Please circle i**f you have any Pins or Needles, numbness . loss of sensation or weakness ?**

Have you already seen a Doctor or Specialist or Therapist for this condition.

Any tests or treatment? Yes / No

Yes	No	**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. Have you noticed any change in your bowel or urinary habit recently? Constipation/diarrhoea, blood or pain on passing / flow rate?
○	○	D. Have you ever smoked? If Smoker How many/much a Day? ____ When did you Give up?
○	○	E. Is your job or home life particularly stressful at the moment ?_____
		F. How much alcohol do you drink in an average week number of glasses beer wine or spirits

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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 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.

I explicitly 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 retained for eight years (or until I reach 25 in case of a child). I understand that these records will be processed in accordance with your 2018 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 £15,00 may be levied.

Please remember that your body will have undergone some change from any treatment today that will cause some biochemical and physiological change to your body that may be felt as soreness or stiffness. This is entirely an individual process that mighty be most marked after your initial treatment, if you concerns please ring us.

I have read and understood the above information.

Signed: **Date:**