Alexander M Smith
Chiropractor
GCC reg 03026

Patient no. _____

Date: _____

Personal Details – To be filled in by Client

Full Name: _____

Date of Birth: ____/____/_____/ Age:_____ Male Female ☐

Number and age of children: _____/_____

Address:_____

_____ Postcode: _____

Phone no: _____Mobile no: _____

Email address: _____Newsletter: Yes No

Appointment reminder? Yes No Call Email Text

Employment Details:

Occupation: _____Employer: _____

Brief description of daily work:_____

_____

Health Details:

How many hours do you sleep per night? _____ Do you sleep soundly? _____

Do you have sufficient energy for your daily activities? Yes No

Do you exercise? Yes No How often?_____ Type?_____

Please list all current medication / supplements:_____

_____ ☐ ☐

_____

What would you like to achieve from Chiropractic Care?

- ☐ Pain relief
- ☐ More mobility / flexibility
- ☐ Better Health and Vitality (wellness)
- ☐ All of the above

How did you hear about us?

- Self ☐
- Friend / family ☐
- GP ☐
- Yellow Pages ☐
- Website ☐
- Other ☐

GP information:

Name:_____

Surgery:_____

_____

Do you have Medical Insurance?

_____

Company:_____

_____

Membership No:

_____

Contra Indications:

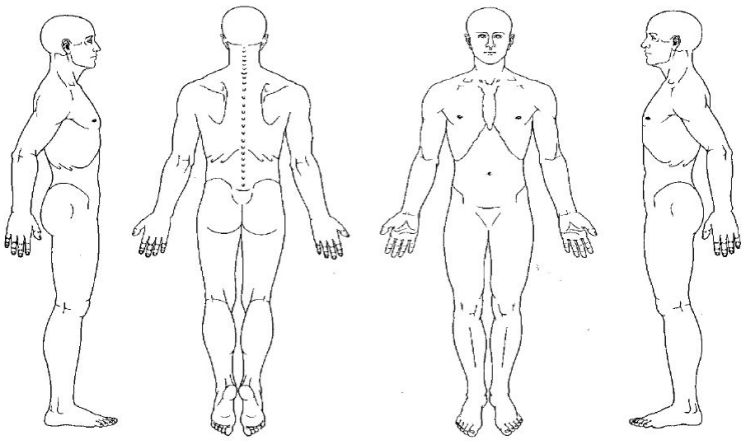
Red Flags

Yellow Flags

Medical History:

Have you(or have you ever) suffered from any of the following: Please tick below

Diabetes	High / low blood pressure	Heart disease
Low blood sugar	Arthritis	Cold hands / feet
Ringing in the ears	Asthma	Anaemia
Skin rashes	Acne	Heart burn
Constipation	Sinus congestion	Yeast infections
Dry skin	Oily skin	Haemorrhoids
Fatigue	Difficult digestion	Scoliosis
High / low cholesterol	Stroke	Depression
Hernias (inguinal / hiatial)	Hepatitis ABC	Nervousness
		Chronic Headaches



Please indicate area of complaint:

Key:

Dull ache:	XXXX
Stiffness:	#####
Sharp Pain:	//////
Tingling:	ooooo
Numbness:	+++++

On a scale of 1-10 (10 being the worst), how would you rate your pain:

Right now: ___/10
At worst? ___/10
At best? ___/10

History of complaint – To be filled in by the Chiropractor

Main complaint

Date / mode of onset

Character / severity

Location / Course

Associated symptoms

Aggravating factors /Relieving factors

Activities affected

Investigations / treatment / outcome to date
Previous episodes
Past medical history
Family history
Medication history / side effects
Red / yellow flags

Physical Examination

Height	Weight	BP	Temp	Resp.	Pulse

Head

Cerebellar Tests
Romberg
Posterior Column
Higher Function Tests
TMJ Tests

Cervical / Thoracic Spine

Axial Compression
Forminal Compression
Cervical Distraction
DeJerines Triad
Shoulder Compression
Shoulder Impingement Tests
TOS Tests
Chest Expansion
Rib Movement
Soto Hall
Slump Test

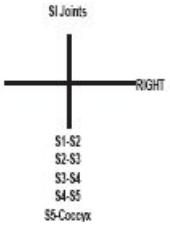
Lumbar / Pelvic / Lower Limb

Trendelenberg
Standing / Standing Kemps
SI Motion Palpation
SLR
Braggard / Bonnet
Gaenslen
Fabere / Thomas / Laguerre
SI Compression / Gapping
Patellar Tracking
Knee Ligamentous Testing
Meniscus Tests
Yeomans
Hibbs
Homer – Pheasant
Apley's Compression / Distraction

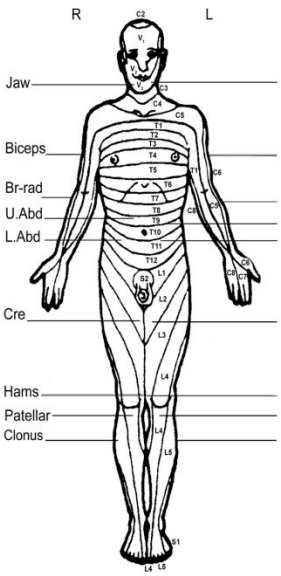
Functional Tests:

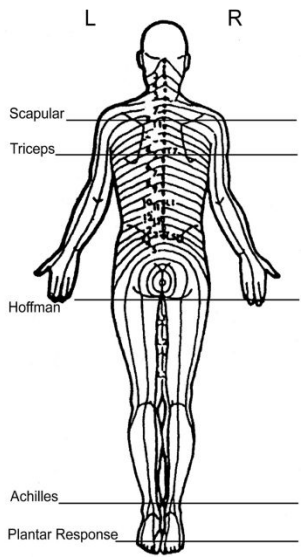
Squat Test
Stork Test
Fukuda / Unterberger's Test
Shoulder Abduction Test
Scapula-Thoracic Rhythm
Chin Poke / Head Drop
Push Up Test
Sit Up Test
Side Bridge
Prone SLR Firing Patterns
Hip Abduction Tests

C	B	A		A	B	C
			C0-C1			
			C1-C2			
			C2-C3			
			C3-C4			
			C4-C5			
			C5-C6			
			C6-C7			
			C7-T1			
			T1-T2			
			T2-T3			
			T3-T4			
			T4-T5			
			T5-T6			
			T6-T7			
			T7-T8			
			T8-T9			
			T9-T10			
			T10-T11			
			T11-T12			
			T12-L1			
			L1-L2			
			L2-L3			
			L3-L4			
			L4-L5			
			L5-S1			



UPPER LIMB			LOWER LIMB		
Muscle / Action	R	L	Muscle / Action	R	L
Deltoid			Hip Flexors		
Triceps			Quadriceps		
Biceps			Tibialis Anterior		
Wrist Extensors			EHL		
Wrist Flexors			Gastroc/Soleus		
Finger Abduction			Peroneus		
Finger Adduction			Toe Walk/Fatigue		
Finger Grasp			Heel Walk/Fatigue		
Finger Extension			Abdominals		





Clinical Impression:

Working Diagnosis and Prognosis:

_____

_____

Treatment plan:

Relief Care:_____

Rehabilitative Care:_____

Wellness Care:_____

Report of Findings:

- ☐ Explain Diagnosis.
- ☐ Explain Plan of Management – Treatment type / frequency / risks.
- ☐ Satisfied that the patient has fully understood ROF and is able to make an informed decision about his/her care.

Signed:_____ Dated:_____

Consent and Data Protection Policy:

I have had a report of findings and have had my condition explained to me. I have been advised that Chiropractic is a safe form of therapy and have had the risks explained. I consent to having treatment with Alexander Smith, Chiropractor

Upon completion of the Patient Details Form, Data Protection and Consent forms, all paper files and information therein may be electronically scanned and stored on a computer file for as long as the patient remains a patient of the clinic and thereafter for a period of 7 years.

I undersigned, acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the practitioner / Chiropractor to maintain the records for the purposes outlined in the policy.

If you are under 16 years of age, this consent should be signed by a parent or legal guardian with parental responsibility.

Signed_____ Dated:_____

Permission to inform other Healthcare Professionals who manage your healthcare

From time to time we may consider it helpful or necessary to inform another healthcare professional who attends yourself (or you child) in order to keep their records updated. In order to pass on your clinical records, we require your consent. May we inform such healthcare professionals with this information?

I, the undersigned, consent to your passing on my clinical case notes to my healthcare professionals as appropriate.

If you are under 16 years of age, this consent should be signed by a parent or legal guardian with parental responsibility.

Signed_____ Dated:_____

Treatment Record

Treatment Number Date	Subjective	Objective	Action	Plan