PARKMORE OSTEOPATHY: NEW PATIENT QUESTIONNAIRE

All information is held in strictest confidence Today's date: _____

Title: _____

Name: _____

Address: _____

_____

Phone (H) _____

(W) _____

(M) _____

Email: _____

Occupation: _____

Height: _____ Weight: _____

Date of Birth: _____

Purpose of visit / main complaint(s):

_____

_____

_____

Your GP's name and address:

_____

_____

Who referred you? _____

How did you hear about this clinic?

_____

Do you have 'Extras' Health Cover?:_____

YOUR HEALTH:

Have you been to an osteopath previously?

_____

Do you have any medical conditions? □ **yes** □ **no**

If so,what?_____

_____

_____

_____

_____

Please list current medications:_____

_____

_____

_____

Have you had any surgery, trauma or hospitalisations? If so, when and for what?

_____

_____

_____

_____

Tests/scans/x-rays of current problem? □ **yes** □ **no**

_____

Do you have high blood pressure? □ **yes** □ **no**

Have you ever had a stroke or TIA? □ **yes** □ **no**

Do you take blood thinning drugs? eg. aspirin or warfrin? □ **yes** □ **no**

Have you ever suffered from:

Skin cancer	□ **yes** □ **no**
Heart disease	□ **yes** □ **no**
Chest pain	□ **yes** □ **no**
Thrombosis/clots	□ **yes** □ **no**
Asthma/bronchitis/breathing difficulties	□ **yes** □ **no**
Dizziness, nausea or fainting	□ **yes** □ **no**
Headaches/migraine	□ **yes** □ **no**
Liver disease/hepatitis	□ **yes** □ **no**
Epilepsy	□ **yes** □ **no**
Chronic Fatigue Syndrome	□ **yes** □ **no**
HIV/AIDS infection	□ **yes** □ **no**
Cancer	□ **yes** □ **no**
Osteoporosis	□ **yes** □ **no**
Diabetes	□ **yes** □ **no**
Urinary infections	□ **yes** □ **no**
Bowel problems	□ **yes** □ **no**
Arthritis	□ **yes** □ **no**
Bone fractures	□ **yes** □ **no**
Incontinence	□ **yes** □ **no**
Dental surgery	□ **yes** □ **no**

Please complete the questions on the reverse side.

Lifestyle

Do you smoke? □ **yes** □ **no**
If so, how many per day for how many years?

_____

Do you take recreational drugs? □ **yes** □ **no**

If so, which ones?_____

Do you have the usual health checks? □ **yes** □ **no**
e.g. blood pressure, pap smear, breast/testes exam)

Please list any significant family medical history:
e.g. Heart attack, high BP, stroke, diabetes, cancer.

_____

_____

What type of exercise do you do? _____

_____

_____

Hours per week: _____

Are you a vegetarian? □ **yes** □ **no**
Do you take nutritional supplements? If so, what?

_____

_____

Is this problem related to a work cover, traffic accident or other insurance claim? □ **yes** □ **no**
Name of insurer/employer _____

_____

Address _____

_____

Claim number/s _____

Date of Injury _____

Contact _____

Contact phone _____

DISCLAIMER: In the event that the insurer denies liability in relation to this claim, I undertake to be responsible for payment for services provided by health care practitioners at this clinic.

Signed _____

Date _____

Women only

Do you have painful periods? □ **yes** □ **no**
At what age did they begin to be painful? _____

Have you had trauma to your pelvis? □ **yes** □ **no**
(e.g. falls, fractures, terminations, operations, D&C, physical violence)
Briefly describe: _____

_____

Do you take 'the pill'? □ **yes** □ **no**
Are you pregnant? □ **yes** □ **no**
If so, how many weeks? _____

When are you due to give birth? _____

How many pregnancies have you had? _____

How many children have you had? _____

Have you had a caesarean? □ **yes** □ **no**
Did you have an episiotomy? □ **yes** □ **no**
Did you tear? □ **yes** □ **no**
Did you have an epidural? □ **yes** □ **no**

Was the labour long or difficult? □ **yes** □ **no**
Any problems with previous pregnancies? □ **yes** □ **no**
List:_____

Did you have a difficult post-natal period? □ **yes** □ **no**

Did you have trouble becoming pregnant? □ **yes** □ **no**
Have you been through menopause? □ **yes** □ **no**
Do you take HRT? □ **yes** □ **no**

_____

Any other comments about you health?

_____

_____

_____

_____

*The personal information that we collect from you enables us to assess your suitability for osteopathic treatment and to aid in your treatment. The information will be used for that purpose only and will be kept securely. You have the right to access and amend the information. If the information you have provided is incorrect, please contact us so that we can effect the relevant changes.