Campden & Broadway Osteopaths
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New Patient Questionnaire

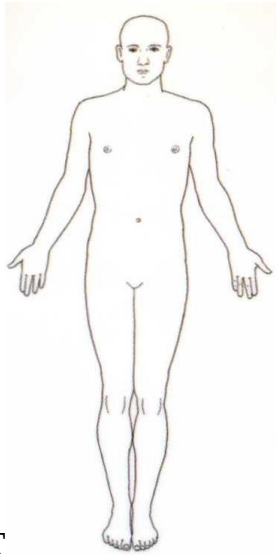
Please complete this form in as much detail as you can. This will not only help your osteopath understand your total state of health, but can help us discover any medical conditions which may need referral to your doctor before you embark on a course of osteopathic treatment.

Your osteopath retains the right to refuse treatment if this form is not completed.

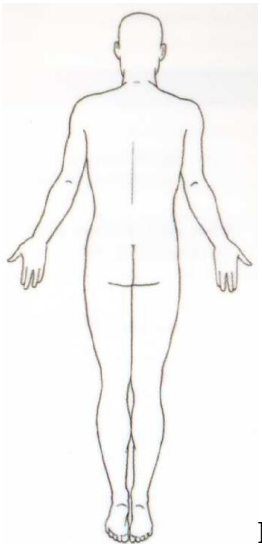
Full Name	**Mr/Mrs/Miss/Ms/other First Names:** **Surname**
Address	 **Postcode**
Telephone	**Home** **Work** **Mobile**
Email	
Date of birth	
Height	
Weight	
Occupation	
Doctor's Name	
Doctor's Address	
Doctor's telephone	
How did you hear about us?	

The information that you provide on this form (and any other information obtained during the course of this treatment) is done so on a strictly confidential basis. This information will be used solely for the purposes of providing osteopathic and/or any related treatment. We will not disclose any personal information that we hold about you outside this practice without your explicit consent, except to the extent we are required or permitted by law.

Draw or shade in the areas of your symptoms and note down any relevant history and dates below:



RIGHT



LEFT **RIGHT**

PAIN SCALE

No Pain Excruciating
0% 50% 100%

1	**Do you have any pins and needles, numbness, loss of sensation or weakness?**
2	**When did this problem start?**
3	**How did this problem start?**
4	**Did the pain come on immediately or did it develop over a period of hours or days?**
5	**Did you have any other symptoms associated with this onset?** *Nausea, vomiting, diarrhoea, cough, dizziness, abdominal pain, loss of bladder or bowel control, etc.*
6	**What did you do/take to relieve the pain? Did it help?**
7	**Please give a brief history of the problem.** *If you have already seen a doctor, specialist or therapist for this condition, give details of any examinations, tests or treatment you have had, giving dates where possible.*

8	**Did you have any Xrays or scans?** *What were the results? Give dates if you can.*
9	**What sort of movements or actions make the pain feel better?**
10	**What sort of movements or actions make the pain feel worse?**
Please give any other details that you think are important or relevant.	
Osteopath's Notes	
MEDICAL HISTORY	
11	**Have you had any serious illness in the past?** *Asthma, diabetes, migraine, rheumatic fever, any illness requiring hospitalisation.*
12	**Have you had any accidents or broken bones?** *Car accidents, whiplash injuries, anything requiring hospital treatment, even in childhood.*
13	**Have you had any operations?** ***T****onsils, appendix, gall bladder, hysterectomy, dental surgery, moles or birth marks,* ***anything*** *requiring an anaesthetic.*
14	**Are you on any medication?** *Sleeping tablets, contraceptive pill, inhalers, creams, ointments, homeopathic or herbal medicine, vitamins and minerals* ***(Any and all pills, capsules, creams or lotions that you may be using for whatever reason)***
15	**Do any of your family (parents, grandparents or children) have any of the following?** *TB, epilepsy, asthma, eczema, hay fever, heart/circulation problems, cancer, diabetes, glaucoma.*
16	**Are you allergic to anything?** *Drugs, foods, pollen, stings, etc.*

DIETS & SOCIAL HABITS	
17	**What do you eat in an average day?** *Are you a vegetarian, vegan, wheat or dairy free? Are you allergic or intolerant to any foods?* **Please give an example of an average day?** **Breakfast:** **Lunch:** **Dinner:** **Snacks:**
18	**How many cups of tea and/or coffee do you drink in a day?** *Give details of milk/sugar.* **Tea:** **Coffee:** **Other:** *(Fruit juice/squash/herb tea/water)*
19	**Do you get thirsty a lot?** *If yes, have you ever been tested for diabetes?*
20	**How much alcohol do you drink in an average week?** *Number of glasses of beer, wine or spirits?*
21	**Do you smoke?** *Give details of number of cigarettes, cigars, ounces of tobacco per day.*
22	**Have you ever smoked? If yes how much and when did you give up?**
23	**Is your job or home life particularly stressful at the moment?** *If yes, do you wish to discuss this at your appointment?*
Osteopath's Notes	
GASTROINTESTINAL HISTORY	
24	**Do you have any indigestion or stomach problems?** *Give details of any investigation and treatments with dates if possible.*
25	**Do you open your bowels regularly?** *Tick where appropriate.* *More than once a day/Once a day/Every other day/Every 2 days/Every ….Days*
26	**Do you use a laxative?** *If yes, which make, how many and how often?*
27	**Have you noticed any change in your bowel or urinary habit recently?** *Constipation, diarrhoea, blood and/or pain on passing stool.*

URINARY HISTORY	
28	**How often do you pass water every day?** *Circle as appropriate* *1-3 times/ 4-6 times/ 7-9 time/ 10-12 times/ 13-15 times/ more….,*
29	**Do you have to get up to go to the toilet at night?** *Circle as appropriate* *Never/ Rarely / Occasionally / Once / 2-3 times / 4-5 times / more…..*
30	**Do you have any bladder, kidney or other urinary problems?** *Cystitis, incontinence, urgency, leaking.* *Give details of any investigations and treatments you have had including approximate dates.*
Osteopath's Notes	
Female Patients Go To Question 34	
31	**Have you noticed any change in urinary habit recently?** *Difficulty stopping or starting, flow rate, blood in urine, increase in frequency.*
32	**Have you ever had a prostate examination?** *If yes, give reason for the tests and the results, including approximate dates.*
33	**Have you ever noticed any pain or swelling in the testicles?** *If yes, did you seek medical advice? What were the results of the tests? Please give approximate dates.* **If you have any swelling or lumps in the testicles, even if they are painless you should consult your GP.**
CARDIOVASCULAR & RESPIRATORY HISTORY	
34	**Do you have any heart or circulatory problems?** *Angina, palpitations, chest pains in cold or windy weather or on exertion, shortness of breath, varicose veins, thrombosis, high blood pressure.*
35	**When was the last time you had your blood pressure taken?** *Do you know what it was?*
36	**Do you have nasal, sinus, chest or lung problems?** *Bronchitis, asthma, catarrh, breathing problems, etc.*
Osteopath's Notes	

GENERAL MEDICAL HISTORY	
37	**Have you had any fainting fits, blackouts, giddiness or dizziness?** *Give details of when they occurred and any medical tests you have had.*
38	**Do you have any skin problems?** *Are you using any medication? Give details.*
39	**Do you have any tinnitus (ringing in ears), deafness or other hearing problems?** *Give details of any investigations or treatments with approximate dates.*
40	**Do you have any loss or blurring of vision?** *Give details of any investigations or treatments with approximate dates*
41	**Do you have any sleeping problems?** *Give details of any investigations or treatments with approximate dates*
42	**Do you ever get "Night Sweats"?** *Give details of any investigations or treatments with approximate dates*
43	**Do you do any sports of hobbies?** *Give details of how often and to what level.*
Osteopath's Notes	
Male Patients Go To Question 52	
GYNAECOLOGICAL HISTORY	
44	**Do you have periods?** *If you are post menopausal or have had a hysterectomy please go to Question 46* **If yes, what are they like?** *How long does your period last?.....Days. How long in between periods?……Days/weeks*
45	**Do you have a coil fitted?**
46	**Have you had a mammogram?** *If yes, how long ago? What were the results?*
47	**When was your last cervical smear?**

48	**Do you have any children?** *If yes, give birth weights and any problems there may have been with the pregnancies or births, eg. Caesarean, ventouse, forceps, etc.* *Male/female Birth weight Problems with labour/birth Age now*
49	**If you are post menopausal, how old were you when your periods finished?**
50	**Are you currently taking, or have you ever taken and Hormonal Replacement Therapy?** *Please give the name of the HRT and how long you had, or have been taking it.*
51	**If you are post menopausal, have you had a bone density scan (DXA scan or Ultra Sound scan)?** *If yes, when was it and what were the results?* *Has anyone in your family been diagnosed with osteoporosis?* *Have you ever taken oral steroids, anticonvulsants or diuretics for any length of time?*

GENERAL QUESTIONS

52	**Do you have, or have you had, any illnesses or problems that have not been covered by this questionnaire?**
53	**Do you have any questions or anxieties about osteopathic treatment that you would like to discuss at your consultation?**

The Data Protection Act ("The Act") lays down certain requirements for the protection against unauthorised disclosures of personal information. The Act also gives you certain rights. In order that we may use your personal information for the purposes of providing osteopathic and/or any relevant treatment, we are obliged to obtain your written consent. **Accordingly, we would be obliged if you would sign the consent section below.**

I consent to the use of my personal information for the purposes set out above. I also confirm that the information I have provided in this form and during the course of my treatment is, to the best of my knowledge, accurate and complete.

Signature of patient:_____ Date: _____.
(If the patient is a child, then the signature of their parent or legal guardian)

If you **DO NOT** consent to your doctor being informed that you are receiving osteopathic treatment please mark an **X** in the box.	

Thank you.