

TITLE FIRST NAME LAST NAME

TEL HOME WORK MOBILE

EMAIL DATE OF BIRTH (DD/MM/YY) / /

ADDRESS

ADDRESS POSTCODE

OCCUPATION EMPLOYER

GP

(CONSULTANT / SPECIALIST ~ IF RELEVANT)

How did you hear about us ? If you were referred / recommended please state by whom.

MEDICAL QUESTIONNAIRE

Please list any medical disorders, medication or supplements that you take. If you don't know the names of an just medication just say what it is for.

Please tick any of the following that **CURRENTLY** apply to you:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Night sweats. | <input type="checkbox"/> Extreme lack of energy | <input type="checkbox"/> Unexplained breathlessness | WOMEN ONLY |
| <input type="checkbox"/> Feel unwell. | <input type="checkbox"/> Can be unduly hot / cold. | <input type="checkbox"/> Bowel or bladder problems or changes e.g. constipation, diarrhoea, incontinence, reduced urine flow etc | <input type="checkbox"/> currently pregnant |
| <input type="checkbox"/> Pain that stops you sleeping. | <input type="checkbox"/> Constant pain unaffected by movement or position. | | number of previous pregnancies ____ |
| <input type="checkbox"/> Unexplainable loss of weight or appetite. | <input type="checkbox"/> under extreme stress | <input type="checkbox"/> Any other recent changes in any bodily function | |

Do you have or **EVER HAD** any of the following ?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Digestive or eating disorder | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Major injury | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Circulatory or heart condition | <input type="checkbox"/> A pacemaker | <input type="checkbox"/> Headaches/migraine | <input type="checkbox"/> Major illnesses |
| <input type="checkbox"/> Bladder or Bowel problem | <input type="checkbox"/> Been a smoker | <input type="checkbox"/> (Rheumatoid) Arthritis | <input type="checkbox"/> Long term steroids |
| <input type="checkbox"/> Neurological problem e.g.stroke or epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Gynaecological problems | <input type="checkbox"/> Major surgery including Cessarian |

If you have ticked any box please provide further details. If you need more space please write on the back

By signing this form I confirm and agree that:

- If my treatment is paid for by a third party (e.g. medical insurer) I am ultimately responsible for the full cost of my treatment in the event of any ineligibility to treatment or shortfall in payment e.g. due to an excess applying to my policy (medical insurance patients please fill in separate form).
- Should I fail to attend an appointment without giving 24 hours notice of cancellation I agree to pay the applicable late cancellation fee (usually the full appointment fee) OR in the event of receiving funded treatment by a third party I understand the missed appointment will still count as one of my funded sessions.
- I consent to treatment by therapist in attendance

Signature: _____ Date: _____

Occasionally, Spine Plus (Osteopathy Plus Ltd) would like to email you about health tips, our latest information, new services or offers. If you DO NOT wish to receive this information please tick here: