New Patient Questionnaire – Male

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 determine if there are any medical conditions which may need referral before you embark on a course of osteopathic treatment. All information given is treated with the strictest patient/practitioner confidentiality and governed by data protection rules.

Mrs/Miss/Ms/ other (please state) *: _____ First names *: _____

Surname *: _____ Address *: _____

Post Code *: _____ Home *: _____

Work *: _____ Mobile *: _____

Email *: _____ Date of Birth *: _____ dd / mm / yyyy

Height *: _____ Weight *: _____

Right or Left handed? *: _____ Occupation *: _____

Doctor's Name *: _____ Doctor's Telephone. *: _____

Doctor's Address *: _____ How did you find out about us? *: _____

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.

Please give a brief history of the reason for your visit.

When did this problem start?: _____ How did this problem start?: _____

Did the pain come on immediately or did it develop over a period of hours or days?:

Did you have any other symptoms associated with this onset? (Nausea, vomiting, diarrhoea, cough, dizziness, abdominal pain, loss of bladder or bowel control, etc.)

What sort of movements or actions make it feel better?:

What sort of movements or actions make it feel worse?:

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

Notes

PAIN SCALE

PAIN SCALE

0 No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Do you have any pins and needles, numbness, loss of sensation or weakness?:

Have you had any X Rays or scans? Please include dates if you can:

What were the results?:

Please give any other details that you think are important or relevant.

Osteopath's Notes

DIET AND SOCIAL HABITS

Do you do any sports or hobbies? Give details of how often and to what level.

How would you describe your diet? Are you a vegetarian, vegan, wheat or dairy free? Are you allergic or intolerant to any foods?

How much alcohol do you drink in an average week? Number of glasses of beer, wine or spirits:

Do you smoke? Give details of number of cigarettes, cigars, ounces of tobacco per day.:

Have you ever smoked? If yes, when did you give up?:

Is your job or home life particularly stressful at the moment? If yes, are you happy to discuss this at your appointment?:

MEDICAL HISTORY

Have you been diagnosed with any illnesses? Such as Asthma, diabetes, migraine, rheumatic fever, high blood pressure or any illness requiring hospitalisation. Please give details

Have you had any accidents or broken bones? Car accidents, whiplash injuries, anything requiring hospital treatment – even in childhood.

Have you had any operations? Tonsils, appendix, gall bladder, hysterectomy, dental surgery, moles removal, anything requiring an anaesthetic.

Are you on any medication? Please list names and dosage 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.

Do any of your family (parents, grandparents or children) have any diagnosed health conditions? Such as TB, epilepsy, asthma, eczema, hay fever, heart/circulation problems, respiratory issues, cancer, diabetes, glaucoma. Please state

Are you allergic to anything? Drugs, food, pollen, stings, etc.:

GASTROINTESTINAL & URINARY HISTORY

Do you have any indigestion or stomach problems? Give details of any investigations and treatments with dates if possible.

Have you noticed any change in your bowel or bladder habits recently? Constipation, diarrhoea, blood and/or pain on passing urine or stool.:

Do you have to get up to go to the lavatory at night? Tick where appropriate

- [ ] Never
- [ ] Rarely
- [ ] Occasionally
- [ ] Once
- [ ] 2-3 times
- [ ] 4-5 times
- [ ] more

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

CARDIOVASCULAR AND RESPIRATORY HISTORY

Do you have any heart or circulation problems? Angina, palpitations, chest pains in cold or windy weather or on exertion, shortness of breath, varicose veins, thrombosis, high blood pressure.

When was the last time you had your blood pressure taken?:

Do you know what it was?:

Do you have any nasal, sinus, chest or lung problems? Bronchitis, asthma, catarrh, breathing problems, etc.:

GENERAL MEDICAL HISTORY

Have you had any fainting fits, black outs, giddiness or dizziness? Give details of when they occurred and any medical tests you have had.

Do you have any skin issues, rashes, eczema, psoriasis?:

Do you have any tinnitus (Ringing in the ears), deafness or other hearing problems? Give details of any investigations or treatments with approximate dates.

Do you have any loss or blurring of vision? Give details of any investigations or treatments with approximate dates.

Do you have any sleeping problems? Give details of any investigations or treatments with approximate dates.

Do you ever get 'Night Sweats'? Give details of any investigations or treatments with approximate dates.

Do you have, or have you had, any illnesses or problems that have not been covered by this questionnaire?:

Do you have any questions or anxieties about osteopathic treatment that you would like discussed at your consultation?:

(Osteopath's Notes – need space to add notes when with the patient Patient hopes and expectations from consultation/treatment Prognosis)

DATA PROTECTION GDRP

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. The information which you give in this form, and any other information obtained during the course of your treatment, is 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 which we hold about you outside this practice without your explicit consent, except to the extent we are required or permitted by law.

Data Protection Policy

Balance 360 uses a database to hold certain information from the patient questionnaire. This information is entered into a database and so technically stored. The Form requires Opt-In consent to add you to our mailing and text messaging lists. •We will never give/sell or rent this data to a third party. •We may add your email address to our Balance 360 mailing list and your mobile telephone number to our Text Local appointment reminder list. •You can lodge a data subject access request: You can email us at any time to remove your personal data from our systems jolene@balance360.co.uk •How long will we hold your personal data: • We are required to retain adult patient notes for eight years following the last appointment • We are required to retain infant and child notes until that child reaches 25 years of age.

GDPR Consent

- [ ] I consent for Balance 360 to store my personal data.
- [ ] I consent to be added to Balance 360 Mailing List.
- [ ] I consent to be added to Balance 360 to receive appointment reminders

Signature *

Print name *: _____ **Date *:** _____ dd / mm / yyyy