# Welcome to Your Spinal Health

**The consultation is designed to find the underlying cause of your problems and the best way to correct it so you can regain full health**

Title _____ Name _____ DOB _____ M/F

Address _____

Email _____

Telephone Home _____Work _____Mobile _____

Occupation _____ GP Practice _____

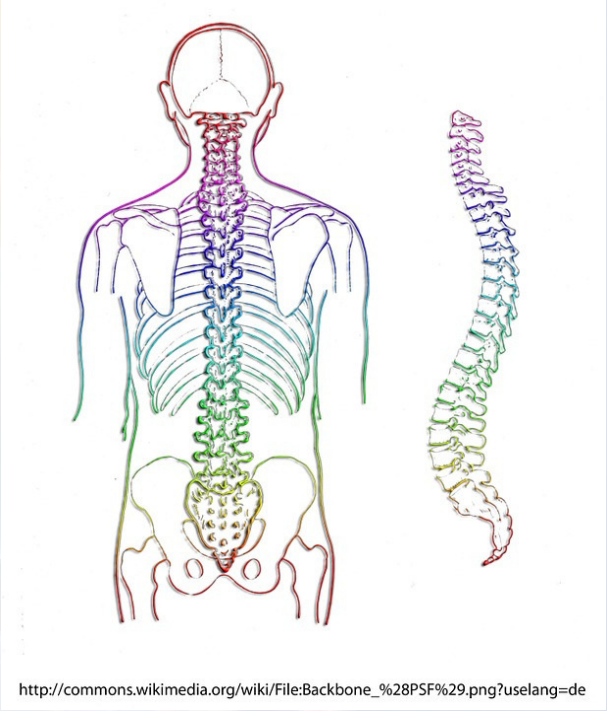
How did you hear of us? _____

**What health issue would you like help with?**
**Mark problem areas on the diagram**

_____
_____
_____
_____
_____
_____

**When and how did it start?**

_____
_____
_____
_____
_____
_____
_____
_____



http://commons.wikimedia.org/wiki/File:Backbone_%28PSF%29.png?uselang=de

_____
_____
_____
_____
_____

## How is this affecting your life?

## What made you decide to sort this out now?

## What treatments have you tried?

## Please list all operations/procedures you have had

## Please list all major accidents you have had

## Please list all scans/X-rays you have had (for any condition)

_____

_____

_____

## Please list any current medical conditions

_____

_____

_____

**Are you currently seeing a specialist? Y/N** _____

## Please list any medication or supplements

_____

_____

_____

## What would be your ideal outcome from treatment?

_____

_____

_____

## On a scale of 1 (poor) to 10 (excellent) please score yourself on your :-

Eating habits _____ Exercise habits _____ Sleep _____ General health ____

Posture _____ Energy _____ Happiness _____ Motivation ____

## Which of these do you have/have had? :-

0 Allergies
0 Ankle swelling
0 Cancer
0 Constipation
0 Difficulty breathing
0 Eczema/skin problems
0 Grinding teeth
0 High blood pressure
0 Joint swelling
0 Loss of vision
0 Palpitations
0 Prostate problems
0 Dental work
0 Anxiety/stress
0 Angina
0 Chest pains
0 Cystitis
0 Difficulty urinating

0 Indigestion/reflux
0 Loss of balance
0 Low blood pressure
0 Period pains
0 Rapid weight loss
0 Varicose veins
0 Arthritis
0 Bladder infections
0 Cold sweats
0 Diabetes
0 Dizziness
0 Eye problems
0 Heart attacks
0 Irregular periods
0 Loss of consciousness
0 Numbness
0 Pins and needles
0 Sinus problems

0 Asthma
0 Bloating/gas
0 Chronic thrush
0 Diarrhoea
0 Eating disorder
0 Fatigue/tiredness
0 Hearing problems
0 Jaw pain/clicking
0 Loss of taste/smell
0 Orthodontic work
0 PMT
0 Stroke/TIA
0 Recurrent tonsillitis
0 Recurrent earaches
0 Poor circulation
0 Epilepsy/seizures
0 Headaches
0 Visual disturbances

## Are the other members in your family in good health?

_____

_____

Children? Y/N Ages _____

We do have family care plans to look after your whole family - please ask

## Please sign to give us permission to examine and treat you

I confirm that I have understood the information given to me regarding my health condition, the proposed care and possible reactions to care. I understand that Your Spinal Health will use their skills to keep my nerves clear so I can achieve the best health possible. I give my consent to examination and treatment as appropriate

SIGNED PATIENT/PARENT/GUARDIAN DATE

## How we will use the information we collect about you

I understand that Your Spinal Health will use the information they collect to keep me updated by email, text or post on my progress and send me information, including marketing, about products and services which could help me. All information collected will be treated in the strictest confidence and in accordance with the General Data Protection Regulations. We will not share your information with any third party without your written permission and will never sell your information. I give my consent for the use of my data in this way

SIGNED PATIENT/PARENT/GUARDIAN DATE