OXFORD CHIROPRACTIC CLINIC QUESTIONNAIRE

SURNAME:..

FIRST NAMES:..

HOME ADDRESS:..

....

.... PostCode.......................................

HOME TEL + CODE:...

WORK TEL + CODE:...

MOBILE No:...

RECCOMMENDED/REFERRED BY:...

PRIVATE HEALTH PLAN: ie BUPA..

OCCUPATION:..

DATE OF BIRTH:.....................................

AGE:...

MARITAL STATUS:...................................

SPOUSE'S NAME:....................................

CASE NO:..

DATE:...

DC:..

CHILDREN'S NAMES:..

BUSINESS ADDRESS:...

EMAIL ADDRESS:..

MEDICAL DOCTOR:..

ADDRESS:..

DENTIST:...

ADDRESS:..

PRESENT COMPLAINT:...

DATE OF ONSET & DURATION:...

TREATMENT TO DATE:..

PREVIOUS DIAGNOSIS:...

X-RAYS: WHERE AND WHEN WERE THEY TAKEN?..

ARE YOU INSURED WITH A PRIVATE HEALTH PLAN?:..

ARE YOU SEEKING: TEMPORARY RELIEF ONLY ☐ RELIEF AND OPTIMUM CORRECTIVE CARE ☐ ONGOING CARE ☐

CONFIDENTIAL HEALTH QUESTIONNAIRE
(Please tick where applicable)

IN ORDER TO HELP US ASSES YOUR HEALTH PROFILE THOROUGHLY, PLEASE ANSWER THE SEEMINGLY ARDUOUS QUESTIONS BELOW AS ACCURATELY AS POSSIBLE

HEADACHES	☐	EYE PAIN	☐	CHEST PAINS	☐	BELCHING/GAS	☐
MIGRAINES	☐	EYE SQUINT	☐	HIGH BLOOD PRESSURE	☐	POOR APPETITE	☐
CONVULSIONS	☐	DETERIORATING VISION	☐	LOW BLOOD PRESSURE	☐	HAEMORRHOIDS (PILES)	☐
DIZZINESS	☐	LOSS OF WEIGHT	☐	VOMITING	☐	BLOOD IN URINE	☐
FAINTING	☐	LOSS OF ENERGY	☐	VOMITING BLOOD	☐	FREQUENT URINATION	☐
ALLERGIES	☐	DEAFNESS	☐	NAUSEA	☐	PAINFUL URINATION	☐
SINUS INFECTION	☐	EARACHE	☐	NERVOUSNESS	☐	POOR BLADDER CONTROL	☐
NASAL OBSTRUCTION	☐	EAR DISCHARGE	☐	SWOLLEN JOINTS	☐	KIDNEY INFECTIONS	☐
HAYFEVER	☐	EAR NOISES	☐	INDIGESTION	☐	SEXUAL IMPOTENCY	☐
NOSE BLEEDS	☐	JAW PAIN	☐	HEARTBURN	☐	CVA / STROKE	☐
FREQUENT COLDS	☐	FACIAL PAIN	☐	ULCERS	☐	LOSS OF SLEEP	☐
SORE THROATS	☐	BRONCHITIS	☐	CONSTIPATION	☐	ENLARGED GLANDS	☐
HOARSENESS	☐	PALPITATIONS	☐	DIARRHOEA	☐	HIV POSITIVE	☐

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

ASTHMA	☐	ECZEMA	☐	HIATUS HERNIA	☐	PSORIASIS	☐
ANAEMIA	☐	ENCEPHALITIS	☐	JAUNDICE	☐	PNUEMONIA	☐
ANGINA	☐	EPILEPSY	☐	KIDNEY STONES	☐	POLIO	☐
APPENDICITIS	☐	GALL STONES	☐	LIVER DISORDERS	☐	PROSTATE	☐
ALCOHLISM	☐	GLANDULAR FEVER	☐	LUMBAGO	☐	RHEUMATIC FEVER	☐
ARTHRITIS	☐	GOITRE	☐	MENINGITIS	☐	SMALL POX	☐
CANCER	☐	GOUT	☐	MENTAL DISORDERS	☐	TONSILITIS	☐
DIABETES	☐	HEART DISEASE	☐	PLEURISY	☐	TUBERCULOSIS	☐

DO YOU SUFFER FROM PAIN AND / OR SWELLING:

FACE	☐	SHOULDERS	☐	WRISTS	☐	ABDOMEN	☐	KNEES	☐
HEAD	☐	ARMS	☐	CHEST	☐	LOW BACK	☐	ANKLES	☐
NECK	☐	ELBOWS	☐	MID BACK	☐	HIPS	☐	FEET	☐

DO YOU SUFFER FROM PAIN AND / OR SWELLING:

DO YOU HAVE PAIN IN THE JAWS?:..

CLICKING JAW / LOCKING JAW WHEN OPENING:..

DO YOU GRIND YOUR TEETH?..

DO YOU WEAR DENTURES? UPPER JAW ☐ LOWER JAW ☐

HAVE YOU WORN AN ORTHODONTIC BRACE?:...

HAVE YOU HAD ANY PERMANENT TEETH REMOVED?:......................................