If you have downloaded this form from our web site and **have a booked appointment**, please complete the form prior to your visit. Please date and sign it at your appointment.

Name ..... Age..... D.O.B. ……/……/…….

Address.....Post Code: ……. Phone……..Mobile …….

Occupation …… Status: S. M. D. W. Partner/Spouse. No. of children .....

First Language ……. Emergency Contact: Name: …… Relationship: ……..…Phone…….

Referred by: ….…….. **Health Insurance ……**

HEALTH HISTORY RELATING TO TREATMENT

1.Have you had any serious illness such as Rheumatic Fever. Diabetes. Heart Ailments,

Epilepsy, Kidney Disease, High Blood Pressure or Asthma? …….

2.Do you suffer from breathlessness or swollen ankles or pains in the chest? ……

3.Are you at present receiving medical attention of any type? ……..

4.Have you ever had allergies or adverse reactions to any drugs? ……

Any Radiation Therapy? …… Relevant XRays / CT / US / MRI scans? …….Any fractures or serious injury? ……

Any surgery (state type and date of operation) ……..

5. Any previous osteopathic or chiropractic care? YES / NO If yes name of Practitioner ……

PRESENT PROBLEMS –

6. MAJOR COMPLAINT

7. Other problems in order of severity (a) ……(b) ……

(c) …….. (d) ……

8. F0R WOMEN ONLY— Is there any possibility of you being pregnant? ……

Your Signature ..... Today's Date: ……/……../……..

DURING THE CURRENT COURSE OF TREATMENT ANY CHANGE IN ABOVE DETAILS SHOULD BE REPORTED