Name: ..... **D. O. B.:** .....

Address: ..... **Telephone:** .....

..... **Email:** .....

..... **Occupation:** .....

Name and address of GP: .....

.....

DO YOU CONSENT TO YOUR G.P. BEING INFORMED YES/NO

Please check the appropriate box for any of the following symptoms, which you have now or have had previously. We need all the facts about your health before we accept your case. ***THIS IS A CONFIDENTIAL HEALTH REPORT.***

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Loss of energy	☐	☐	Low blood pressure	☐	☐	Poor appetite	☐	☐	Prostate
☐	☐	Loss of weight	☐	☐	Swelling ok ankles	☐	☐	Nausea	☐	☐	Arthritis
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Vomiting	☐	☐	Cancer
☐	☐	Fainting	☐	☐	Stroke	☐	☐	Poor bladder control	☐	☐	Depression
☐	☐	Convulsions	☐	☐	Bruise easily	☐	☐	Dizziness	☐	☐	Migraine
☐	☐	Loss of sleep	☐	☐	Tremors	☐	☐	Psoriasis	☐	☐	Asthma

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐
Smear	☐	☐	☐	☐
Self breast exam	☐	☐	☐	☐
Self testicular exam	☐	☐	☐	☐

HAVE YOU EVER:	YES	NO
Been knocked unconscious?	☐	☐
Used a cane, crutch or other support?	☐	☐
Been treated for a spine or nerve disorder?	☐	☐
Had a fractured bone?	☐	☐
Been hospitalised for surgery?	☐	☐
Been hospitalised for other than surgery?	☐	☐

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other .....

During the past month, has it been too painful to do many of your day-to-day activities? (If Yes how often)

.....

During the past month, has your pain been bad enough to often make you feel worried or low in mood?

.....

PLEASE MARK THE DIAGRAMS WITH YOUR CURRENT PROBLEM, USING THE KEY BELOW

Please diagram your pain:

1. Circle areas of pain

2. Mark the Most painful spot with an 'X'

3. Use arrows to show where the pain goes (radiates)

4. Mark any areas of numbness/ tingling with an 'N'or 'T'