CONFIDENTIAL HEALTH QUESTIONNAIRE

FULL NAME (state title) ..... **MARITAL STATUS: S** ☐ **M** ☐ **W** ☐ **D** ☐ **Co-Habiting** ☐

DATE OF BIRTH ..... **TEL (Home)** .....

ADDRESS ..... **TEL (Mobile)** .....

..... **TEL (Work)** .....

POST CODE ..... ***E-Mail Address*** .....

OCCUPATION .....

G.P NAME/ADDRESS .....

Do you object to us contacting your GP? .....

Who referred you to this clinic OR how did you find out about this clinic? .....

PRESENT COMPLAINT: .....

DATE OF ONSET: .....

WHAT MAKES IT WORSE? .....

WHAT IMPROVES IT? .....

PREVIOUS DIAGNOSIS? .....

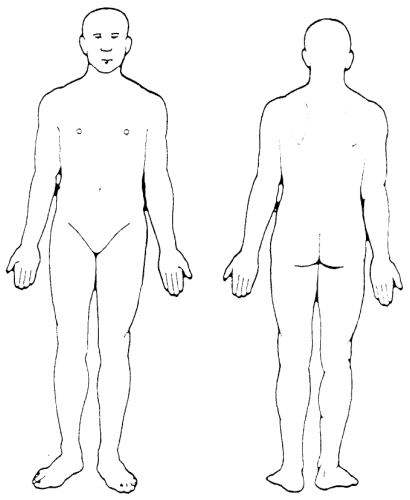
WHAT MEDICATION ARE YOU ON? .....

HAVE YOU HAD X-RAYS? .....

WHEN WAS THE LAST TIME YOU REALLY FELT GOOD?

.....

Please shade all the areas of pain you are experiencing



Do you want to:

☐ **Just get out of pain**

☐ **Just get out of pain and stop it returning**

☐ **Keep healthy once you are right**

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

Heart Problems	☐	**Irritable bowel**	☐	**Depression**	☐	**Prostate problems**	☐
Alcoholism	☐	**Constipation**	☐	**Drug dependency**	☐	**Osteoporosis**	☐
Diabetes	☐	**Weight loss**	☐	**Thyroid problems**	☐	**Allergies**	☐
Cancer	☐	**Digestive problems**	☐	**Eating Disorders**	☐	**Arthritis**	☐

DENTAL HISTORY

Do you have pain in the jaw	☐	**Have you ever had dental surgery/extractions**	☐	**Do you grind your teeth**	☐
Clicking/Locking jaw	☐	**Have you ever worn an orthodontic brace**	☐	**Do you wear dentures**	☐

DIETARY INTAKE PER DAY

No glasses of: **Tea** _____ **Coffee** _____ **Cola** _____ **Water** _____

Amount of: **Sugar** _____ **Chocolate** _____ **Alcohol** _____ **Tobacco** _____

FEMALE PATIENTS: **Number of children:** ☐

Pre-menopausal: **For x-ray purposes, please state date of onset of your last menstrual period** .....

Is there possibility any, however small, that you may be pregnant **Yes** ☐ **No** ☐

SIGNATURE: ..... **DATE:** .....