Newcastle Osteopathy

Patient Questionnaire

Date ________

Personal Details

Name ______________________________

Address ______________________________

____

Phone (H) ______________________________
(W) ______________________________
(M) ______________________________

Email ______________________________

Occupation ______________________________

Height ____________ Weight ____________

Date of birth ______________________________

Purpose of visit/ main complaints

____

____

____

GP's name & address ______________________________

____

How did you hear about Newcastle Osteopathy?

____

Your Health

Have you been to an Osteopath previously? ☐ yes ☐ no

Do you have any medical conditions? ☐ yes ☐ no
If so, what ______________________________

____

Have you had any surgery, trauma or hospitalisation? ☐ yes ☐ no

If so, what ______________________________

Please list any current medications ______________________________

____

Do you have high blood pressure? ☐ yes ☐ no

Have you ever had a stroke or TIA? ☐ yes ☐ no

Do you take blood thinning drugs? ☐ yes ☐ no
(eg. Aspirin, Warfarin)

Do you take steroids? ☐ yes ☐ no

Do you take anti-inflammatories? ☐ yes ☐ no

Have you suffered from any of the below? (Please tick box)

	Yes
Arthritis	☐
Osteoporosis	☐
Diabetes	☐
Bone fractures	☐
Cancer	☐
Skin cancer	☐
Heart disease	☐
Blood Clots	☐
Headaches/ Migraines	☐
Dizziness/ Nausea	☐
Asthma	☐
Liver disease	☐
HIV/AIDS	☐
Incontinence	☐

The personal information that we collect from you enables us to assess your suitability for osteopathic treatment and to aid in your treatment. This information will be used for that purpose only & will be kept confidential. You have the right to access and amend this information. If any of the information you have provided is inaccurate please contact us so that we can effect the relevant changes.

Newcastle **Osteopathy**

Patient Questionnaire

Lifestyle

Do you smoke? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no

If so, how many drinks per week? ________________

Do you sleep on your front? ☐ yes ☐ no

Do you have regular health checks? ☐ yes ☐ no
(eg. Blood pressure, pap smear, breast exam)

Please list any significant family history
(eg. Cancer, arthritis, blood pressure, diabetes)

____

____

____

____

Do you exercise/play sport? ☐ yes ☐ no

If so, what type? ________________________

Are you vegetarian/vegan? ☐ yes ☐ no

What nutritional supplements do you take?

____

Is this problem related to WORKCARE or an INSURANCE CLAIM? ☐ yes ☐ no

Name of insurer/employer? ____________________

____

Address ________________________________

____

Claim Number/s __________________________

Contact ________________________________

Contact phone ___________________________

Signed: ________________________________

Date: __________________________________

Women Only

Do you have irregular or painful periods? ☐ yes ☐ no

At what age did they begin to be irregular/painful?

____

Have you had trauma to your pelvis? ☐ yes ☐ no

Briefly describe __________________________

____

Are you pregnant? ☐ yes ☐ no

If so, how many weeks? _____________________

How many pregnancies have you had? ___________
How many children have you had?

____

Have you had a caesarean? ☐ yes ☐ no

Did you have any complications during pregnancy or labour? ☐ yes ☐ no

If so, briefly describe _______________________

____

Have you been through menopause? ☐ yes ☐ no

Do you take HRT? ☐ yes ☐ no

All

Any other comments about your health?

____

____

____

____

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____

____

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