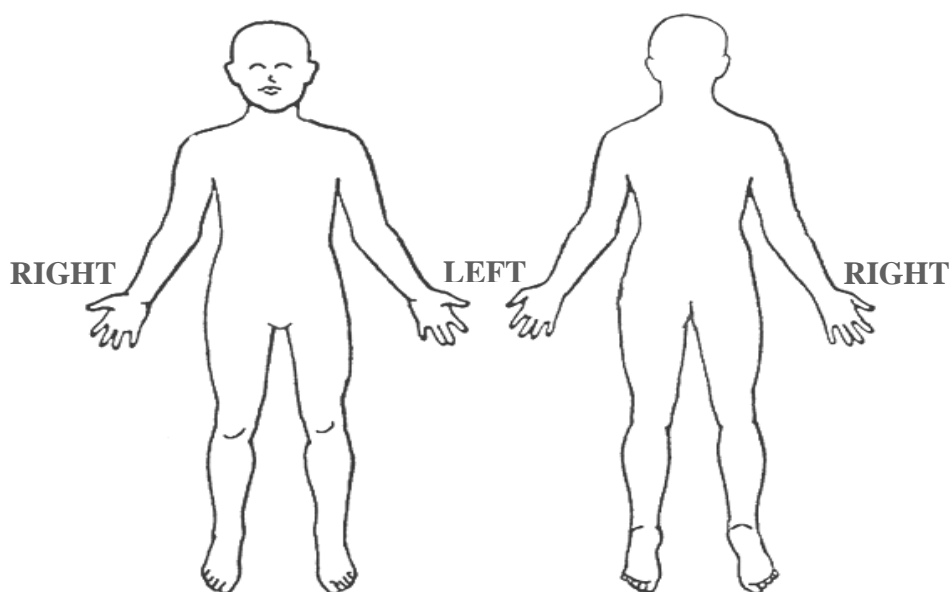


Draw or shade in the areas of your symptoms and note down any relevant history and dates below.



PAIN SCALE

No Pain
0%

50%

Excruciating
100%

1	Do you have any pins and needles, numbness, loss of sensation or weakness?
2	When did this problem start?
3	How did this problem start?
4	Did the pain come on immediately or did it develop over a period of hours or days?
5	Did you have any other symptoms associated with this onset? Nausea, vomiting, diarrhoea, cough, dizziness, abdominal pain, loss of bladder or bowel control, etc.
6	What did you take/do to relieve the pain? Did it help?
7	Please give a brief history of the problem. If you have already seen a doctor, specialist or therapist for this condition, give details of any examinations, tests or treatment you have had, giving dates where possible.

8	<p>Did you have any X Rays or scans? What were the results? Give dates if you can.</p>
9	<p>What sort of movements or actions make the pain feel better?</p>
10	<p>What sort of movements or actions make the pain feel worse?</p>
<p>Please give any other details that you think are important or relevant.</p>	
<p>Osteopath's Notes</p>	
<h2>MEDICAL HISTORY</h2>	
11	<p>Have you had any serious illness in the past? Asthma, diabetes, migraine, rheumatic fever, any illness requiring hospitalisation.</p>
12	<p>Have you had any accidents or broken bones? Car accidents, whiplash injuries, anything requiring hospital treatment – even in childhood.</p>
13	<p>Have you had any operations? Tonsils, appendix, gall bladder, hysterectomy, dental surgery, moles or birth marks, anything requiring an anaesthetic.</p>
14	<p>Are you on any medication? Sleeping tablets, contraceptive pill, inhalers, creams, ointments, homeopathic or herbal medicine, vitamins and minerals. Any and all pills, capsules, creams or lotions that you may be using for whatever reason.</p>
15	<p>Do any of your family (parents, grandparents or children) have any of the following? TB, epilepsy, asthma, eczema, hay fever, heart/circulation problems, cancer, diabetes, glaucoma.</p>
16	<p>Are you allergic to anything? Drugs, food, pollen, stings, etc.</p>

DIETS AND SOCIAL HABITS

17	<p>What do you eat in an average day? Are you a vegetarian, vegan, wheat or dairy free? Are you allergic or intolerant to any foods? Please give examples of an average day?</p> <p>Breakfast: Lunch: Dinner/Supper: Snacks:</p>
18	<p>How many cups of tea and/or coffee do you drink in a day? Give details of milk and sugar.</p> <p>Tea: Coffee: Other (Fruit juices, squashes, herb teas, water, etc):</p>
19	<p>Do you get thirsty a lot? If yes, have you ever been tested for diabetes?</p>
20	<p>How much alcohol do you drink in an average week? Number of glasses of beer, wine or spirits</p>
21	<p>Do you smoke? Give details of number of cigarettes, cigars, ounces of tobacco per day.</p>
22	<p>Have you ever smoked? If yes, when did you give up?</p>
23	<p>Is your job or home life particularly stressful at the moment? If yes, do you wish to discuss this at your appointment?</p>
Osteopath's Notes	
GASTROINTESTINAL HISTORY	
24	<p>Do you have any indigestion or stomach problems? Give details of any investigations and treatments with dates if possible.</p>
25	<p>Do you open your bowels regularly? Tick where appropriate.</p> <p style="text-align: center;">More than once a day/ Once a day / Every other day / Every 2 days / Every Days</p>
26	<p>Do you use a laxative? If yes, which make, how many and how often?</p>
27	<p>Have you noticed any change in your bowel or urinary habit recently? Constipation, diarrhoea, blood and/or pain on passing stool.</p>

URINARY HISTORY

28	<p>How often do you pass water every day? Tick where appropriate</p> <p style="text-align: center;">1-3 times / 4-6 times / 7-9 times / 10-12 times / 13-15 times / more</p>
29	<p>Do you have to get up to go to the lavatory at night? Tick where appropriate</p> <p style="text-align: center;">Never / Rarely / Occasionally / Once / 2-3 times / 4-5 times / more</p>
30	<p>Do you have any bladder, kidney or other urinary problems? Cystitis, incontinence, urgency, leaking. Give details of any investigations and treatments you have had including approximate dates.</p>

Osteopath's Notes

Female patients go to question 34

31	<p>Have you noticed any change in urinary habit recently? Difficulty stopping or starting, flow rate, blood in urine, increase in frequency.</p>
32	<p>Have you ever had a prostate examination? If yes, give reason for the tests and the results, including approximate dates.</p>
33	<p>Have you ever noticed any pain or swelling in the testicles? If yes, did you seek medical advice? What were the results of the tests? Please give approximate dates.</p> <p>If you have any swellings or lumps in the testicles, even if they are painless, you should consult your GP</p>

CARDIOVASCULAR AND RESPIRATORY HISTORY

34	<p>Do you have any heart or circulation problems? Angina, palpitations, chest pains in cold or windy weather or on exertion, shortness of breath, varicose veins, thrombosis, high blood pressure.</p>
35	<p>When was the last time you had your blood pressure taken? Do you know what it was?</p>
36	<p>Do you have any nasal, sinus, chest or lung problems? Bronchitis, asthma, catarrh, breathing problems, etc.</p>

Osteopath's Notes

GENERAL MEDICAL HISTORY

37	Have you had any fainting fits, black outs, giddiness or dizziness? Give details of when they occurred and any medical tests you have had.
38	Do you have any skin problems? Are you using any medication? Give details.
39	Do you have any tinnitus (Ringing in the ears), deafness or other hearing problems? Give details of any investigations or treatments with approximate dates.
40	Do you have any loss or blurring of vision? Give details of any investigations or treatments with approximate dates.
41	Do you have any sleeping problems? Give details of any investigations or treatments with approximate dates.
42	Do you ever get 'Night Sweats'? Give details of any investigations or treatments with approximate dates.
43	Do you do any sports or hobbies? Give details of how often and to what level.

Osteopath's Notes

Male patients go to question 52

GYNAECOLOGICAL HISTORY

44	Do you have periods? If you are post menopausal or have had a hysterectomy, please go to question 46 If yes, what are they like? How long does your period last? days. How long in between periods?days/weeks
45	Do you have a coil fitted?
46	Have you had a mammogram? If yes, how long ago? What were the results?
47	When was your last cervical smear test?

If you are about to have treatment for a neck problem or headaches, it is important that you read and sign this leaflet before continuing with your treatment.

Legislation will soon require that all patients needing high cervical spine (upper neck) manipulation **must** be informed of the potential risks of such a manipulation before any 'High Velocity Low Amplitude Techniques' can be used in this area. (The type of manipulation that causes a "Click" or "Popping" sound). There have been occasions, following manipulation of the neck, where stroke-like symptoms and, **in extremely rare cases**, severe injury or death has resulted. Although this legislation has not been introduced in this country we feel that in the best interests of our patients this protocol should be included in this practice.

Comparison of statistics for serious injury following:

Cervical manipulation.

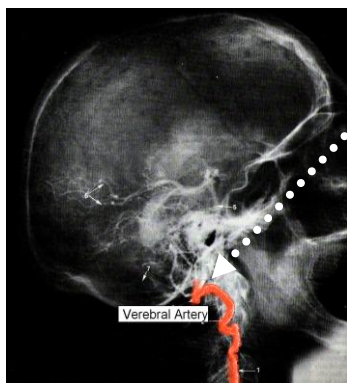
Deaths from gastrointestinal bleeding due to anti inflammatories.

Fatal or serious injuries due to road traffic accidents

Type of Accident	Statistics quoted	Number per 1,000,000
Strokes following cervical manipulation ¹	0.6 per 1,000,000	0.6
Deaths following gastrointestinal bleeding due to anti inflammatories ²	400 per 1,000,000	400
Fatal or serious injury due to road accidents ³	75 per 100,000	750

Sources

- 1 The Department of Health 2001
- 2 A risk assessment of cervical manipulation vs NSAIDs for the treatment of neck pain, *The Journal of Manipulative and Physiological Therapeutics* 1995; 18(8): 530-536
- 3 Government National Statistics West Midlands 1994 -1998



A healthy vertebral artery can easily tolerate the stretching involved in an upper cervical manipulation without any ill effects.

If the vertebral artery has already been damaged (**Vertebral Artery Dissection** or **VAD**): by previous injury or, if it already has some inherited, genetic weakness, it can be vulnerable as it winds around the atlas (the top cervical vertebra, located just below the head) to enter the skull. In these cases any further extension or twisting motions may stretch the artery and tear the delicate or weakened lining (this causes sudden, extremely severe 'thunderclap' headaches or neck pain). A thrombus (small blood clot) can then form over the injured artery wall which can break off and travel along the artery to the brain, causing a stroke or T.I.A. In some cases, the artery may go into spasm, causing transient dizziness and nausea; difficulty speaking or swallowing and visual disturbances.

There are many everyday factors that can cause an injury to the vertebral artery in those that are susceptible. These include such everyday actions as:

- * Ceiling painting
- * Reversing the car
- * Nose blowing
- * Sneezing
- * Coughing
- * Judo
- * Tennis
- * Minor neck trauma
- * Yoga
- * Visit to the hairdressers
- * Reversing the car

Certain medical factors can also increase your chances of sustaining VAD:

- * Hypertension (High blood pressure) (48% in one series)
- * More common in females
- * Oral contraceptive use
- * Chronic headache syndromes
- * Vascular pathology
- * Migraine
- * Smoking
- * Anticoagulants

Vertebral Artery Dissection most commonly occurs in people aged 30 – 45 years and is rare in those over 60 years

Before undergoing your treatment please look through the list below and tick the appropriate box if you have developed any of these symptoms recently or associate them with your neck pain or headache.

- Sudden onset "Thunderclap" head or neck pain. (Sever pain, unlike anything you have experienced before)
- 'Drop attacks', black outs, loss of consciousness
- Nausea, vomiting
- Dizziness, vertigo (associated with position of the head)
- Unsteady gait or feeling of weakness
- Tingling or numbness around the mouth
- Altered facial sensation
- Difficulty speaking or forming words
- Difficulty swallowing
- Tinnitus or deafness

Have you recently been prescribed or are you currently taking any of the following?

- Anticoagulants
Eg: Warfarin
- Oral contraceptives
- Oral steroids
Eg: Prednisilone

Have you recently recovered from any of the following?

- Heart attack, stroke or TIA (transient ischaemic attack)

If you are not sure about any of these questions, please speak to your osteopath.

I have read this leaflet on the risk factors associated with cervical (neck) manipulation, and understand that there is a small (0.6 in 1,000,000) chance of vertebral artery injury following high cervical (upper neck) 'High Velocity, Low Amplitude' techniques.

Please tick the appropriate box to indicate your wishes regarding treatment:

- I **agree** to have cervical (neck) 'High Velocity Low Amplitude' manipulative techniques if my course of treatment at The Osteopathic Practice requires it.
I have read the above and have had my questions regarding the potential risks answered to my satisfaction.
- I **do not agree** to have cervical (neck) 'High Velocity Low Amplitude' manipulative techniques and wish to discuss possible alternatives to this treatment.
I understand that this may require more treatments or more frequent treatments if 'High Velocity Low Amplitude' techniques are not used.

Signature: _____

Date: _____

Fulham Osteopathic Centre

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New Patient Questionnaire

Please complete this form in as much detail as you can. This will not only help your osteopath understand your total state of health, but can help us discover any medical conditions which may need referral to your doctor before you embark on a course of osteopathic treatment.

Your osteopath retains the right to refuse treatment if this form is not completed.

Full Name	Mrs/Mrs/Miss/Ms
Address	
	Post Code
Telephone	Home Work Mobile
Email	Email address
Date of Birth	
Height	
Weight	
Occupation	
Doctor's Name	
Doctor's address	
Doctor's telephone.	
How did you find out about us?	

The information which you give in this form, and any other information obtained during the course of your treatment, is on a strictly confidential basis. This information will be used solely for the purposes of providing osteopathic and/or any related treatment. We will not disclose any personal information which we hold about you outside this practice without your explicit consent, except to the extent we are required or permitted by law.