FULL NAME (state title) ..... MARITAL STATUS S ☐ M ☐ W ☐ D ☐ Separated ☐

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

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

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

POST CODE .....

OCCUPATION ..... *e.mail address* .....

G. P. NAME/ADDRESS .....

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

PRESENT COMPLAINT : .....

DATE OF ONSET : .....

WHAT MAKES IT WORSE? .....

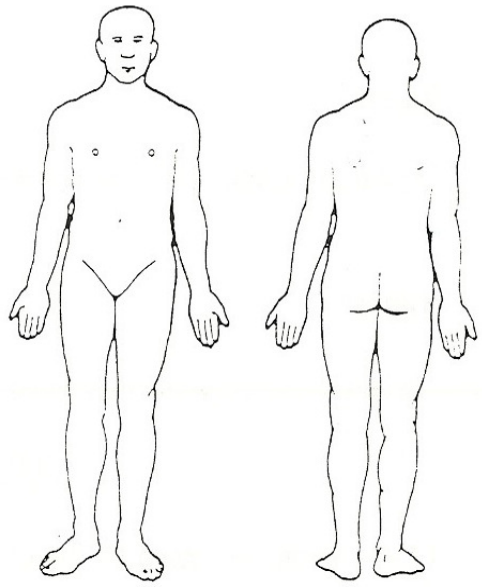
WHAT IMPROVES IT? .....

PREVIOUS DIAGNOSIS? .....

WHAT MEDICATION ARE YOU ON? .....

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

Please shade all the areas of pain you are experi



Do you want to:

☐ Just get out of pain

☐ Just get out of pain and stop it returning

☐ Keep healthy once you are right

How did you find out about this clinic? .....

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING?

Blood pressure	☐	Irritable bowel	☐	HIV	☐	Prostate problems	☐
Angina	☐	Constipation	☐	Drug dependency	☐	Gynaecological problems	☐
Breathlessness	☐	Weight loss	☐	Depression	☐	Allergies	☐
Heart problems	☐	Digestive problems	☐	Glandular fever	☐	Arthritis	☐
Alcoholism	☐	Respiratory problems	☐	Thyroid problems	☐	Eye problems	☐
Diabetes	☐	Eating disorders	☐	Kidney problems	☐	Osteoporosis	☐
Cancer	☐	Hepatitis	☐	Gall stones	☐	Epilepsy	☐

DENTAL HISTORY

Do you have pain in the jaw ☐
Clicking/Locking jaw ☐
Do you grind your teeth ☐

Do you wear dentures ☐
Have you ever worn an orthodontic brace ☐
Have you ever had dental surgery/extractions ☐

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