Healing Hands Healing Minds

Patient Information Questionnaire

NAME ……

DATE OF BIRTH ……..

ADDRESS ……

POSTCODE ……..

MOBILE NUMBER ……

E-MAIL ADDRESS ……

DOCTOR NAME ……

SURGERY NAME ……..

ADDRESS ……

SURGERY CONTACT NUMBER: ……

DO ANY OF THE BELOW APPLY TO YOU?

ARTHRITIS	Y / N
BACK PROBLEMS	Y / N
BREATHING PROBLEMS	Y / N
DEPRESSION	Y / N
DIABETES	Y / N
EYE PROBLEMS	Y / N
HEART PROBLEMS	Y / N
HIGH/LOW BLOOD PRESSURE	Y / N
KNEE PROBLEMS	Y / N

NECK PROBLEMS Y / N
PREGNANCY Y / N
RECENT FRACTURES/SPRAINS Y / N
RECENT OPERATIONS Y / N
OTHER, PLEASE LIST:
……

ARE YOU CURRENTLY RECEIVING ANY MEDICAL TREATMENT? Y / N

ARE YOU PREGNANT OR BREAST FEEDING? Y / N

ARE YOU TAKING ANY CURRENT MEDICATIONS? Y / N
IF YES PLEASE LIST
……

PLEASE SIGN AND DATE TO AGREE THE ABOVE INFORMATION IS CORRECT:

PATIENT SIGNATURE …… **DATE** ……