CITY BACK PAIN CLINIC

Date ___________________

Your Surname ____________________________ Your Forename ______________________

Your Address

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Your Employment

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Your Work Telephone ________________________________

Your Mobile _________________________

Your Email

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GP Name ____

GP Address

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GP Telephone ____

If you could take the time to simply tick the information below and print this form off and bring it with you on your first consultation and treatment it would help me greatly to save time and to tailor a specific treatment plan for your individual needs. Thank you, Chris Curtis MCSP

When was your last physical examination by a doctor or GP? ________________________
Have you had any operations? Yes / No If yes when please? ________________________
Last Gynaecological examination (female) Yes / No If yes when please?_________________
Last Prostate Examination (male) Yes / No If yes when please? ____________________
Do you have any allergies to food or drugs? Yes / No
Have you suffered a stroke? Yes / No If yes when please?_______________________
Has anybody in your family suffered from a stroke? Yes / No
Do you have High blood pressure? Yes / No
Do you have diabetes? Yes / No
Have you ever been diagnosed with cancer? Yes / No
Are you seeing any other Doctors or Therapists? Yes / No
Have you ever had a car crash? Yes / No If yes when please?_______________________
Are you taking any medication? Yes / No If yes please list below

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