PATIENT INFORMATION FORM

bone & body clinic

The Bone and Body Clinic

- Goa - 263 Ponsulem Village, Canacona - 403 702, Goa, India
- Dharamsala - Snow Villa, Dharamkot Village, above McLeod Ganj, Dharamsala, Himachal Pradesh, India

The information you provide in this form is private and confidential. Your case may be discussed with other medical practitioners within our group. Prior approval will be sought if we would like to use your case in any published material.

Note - To edit this electronic version of the form it must be saved on your computer and should be opened using the latest version of Adobe Acrobat Reader.

Name: Male ❑ Female ❑

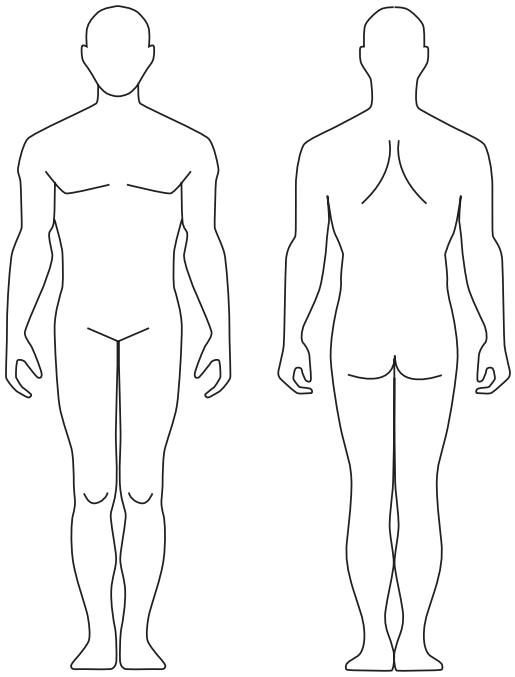
Email address: Phone:

Age: Date of Birth:

Height: Weight:

Please indicate either with arrows/ circles or shading as to where you suffer from pain and discomfort:

Note - You may draw on the diagram to the left using comments or describe any areas of pain and discomfort in the box below:



Have you ever been diagnosed with a condition relating to this pain? No ❑ Yes ❑

Please specify

Have you ever been told you need surgery? No ❑ Yes ❑

Please specify

Have you ever received any treatment in the past for this condition? No ❑ Yes ❑

Please specify

Did you have an accident (even when you were a child)? No ❑ Yes ❑

Please specify

Do you do any sports or fitness activities? No ❑ Yes ❑

Please specify

When you were younger did you play any sports or play any instruments for a long duration of time (1+ years)? No ❑ Yes ❑

Please specify

How many hours do you sleep a night on average:

Usually when you wake up are you:

❑ Quick to get out of bed ❑ Takes time to get up in the morning ❑ It varies from day to day

Do you suffer from migraines and/or headaches? No ❑ Yes ❑

Please specify how often, their severity, how long they usually last and for how long you have suffered.

What is your digestion like? Do you suffer from any of the following:

❑ Bloating
❑ Food intolerance (if so please specify)
❑ Indigestion
❑ Loose bowel movements
❑ Irregular bowel movements
❑ Constipation
❑ Pain after eating
❑ Wind
❑ Other (please give details)

Have you been diagnosed with a condition relating to your digestion? No ❑ Yes ❑
If so please specify

What are your bowel movements like?

❑ Regular (1 or more times per day)
❑ Irregular (not every day) please give average:

Do you need to urinate very often? No ❑ Yes ❑ It varies ❑

Do you have pain when you urinate? No ❑ Yes ❑ It varies ❑

What colour is your urine?

What is your hearing like?

What is your eyesight like?

Do you suffer from any mental related problems?

Do you suffer from depression?

Do you find it hard to concentrate? No ❑ Yes ❑

Please specify

Do you have any liver problems? No ❑ Yes ❑

Please specify

Have you ever suffered from hepatitis? No ❑ Yes ❑

Please specify

Have you ever had malaria? No ❑ Yes ❑

Please specify

Do you get short of breath easily? No ❑ Yes ❑

Do you have any other illnesses such as:

❑ Heart disease
❑ Cancer
❑ Diabetes
❑ Other please specify

Do you currently take any medication? If so please give type, dose and length of time you have taken this.

Have you ever taken medication for an extended period of time? If so, please give details.

Do you smoke tobacco? No ❑ Yes ❑

How many a day?

Do you drink alcohol? No ❑ Yes ❑

How much per week?

What kind of work do you usually do?

For how long have you done this kind of work?

How many hours a day do you do this work?

Have you ever had surgery or medical procedures of any kind?

Please specify

If you are happy that the information contained within this form is correct please sign and date.

Client signature

Date

Registers signature