 Jane Reynolds & Associates

New Patient Form

**With Daniel Baines M.OST**

**Personal details:**

Name:

Age:

Address:

Tel no:

Email:

Job:

Children (how were their births: tearing, episiotomies, C-sections etc):

Work demands:

Sports:

**Introduction**

In order to understand the unique history that has led you to now, I have a fair few questions for you! Just do your best to answer them as fully as possible, then we can figure out which parts relate to your puzzle when we meet in person.

### PART 1

**Presenting complaint:**

What is the problem that you would like help with?:

How it started:

When it started:

Pain scale out of 10 (10 worst):

Things that make the pain worse:

Things that make the pain easier:

Have you seen any practitioners already?

What did they do and did it help?

Is there any morning evening pattern to your pain?

### PART 2

**Past injury history (with approximate dates):**

Feet:

Ankles (including ankle sprains):

Lower legs:

Knees:

Upper leg and groin:

Pelvis and viscera:

Lower back and sacrum/coccyx:

Mid back and ribs:

Shoulders:

Elbows:

Wrists:

Neck:

Head (any bangs/impacts):

Eyes (including vision):

Teeth (including dental work, clicking and grinding):

**Operations and surgery**:

Scars (all important):

Broken bones:

Piercings tattoos:

Accidents (including road traffic accidents, whiplash, falls onto tail bone, concussions and falls):

**Systemic health:**

How is your general health?

Current Medication:

Past medication:

Have you ever had an X-ray/MRI or other investigations and what were they for?

Do you suffer from night sweats, unexplained weight loss, unremitting pain that stops you sleeping?

Your birth details if you know them (ventouse, c-section, complications etc):

Childhood illness:

Hospitalisations:

Cardiovascular (heart) health:

Respiratory health (any shortness of breath, asthma, pneumonia etc.):

Digestion (any reflux, blood in stools etc.):

Gynaecological health (smear tests etc.):

Neurological (headaches, dizziness, loss of sensation or strength):

Alcohol/smoking/drugs:

Stress levels:

Anxiety levels:

Have you ever been diagnosed with cancer?

Have you ever had your bone density levels measured?

Any other medical conditions:

**What would you like to gain most from treatment?**

### PART 3

**Functional health:**

Inmune system

1) Have you been diagnosed with M.E, CFS, Fibromyalgia or Post-viral fatigue?

2). Have you ever been diagnosed with an autoimmune disease? Please specify

3). Have you ever had asthma, allergies or acid reflux? Please specify when

4). Have you ever been diagnosed with a virus? When were you diagnosed? (i.e. Mono, Epstein-Barr, Herpes, chickenpox/shingles?)

5). When stressed, do you experience: cold sores, hives, shingles or chronic fatigue?

6). Have you had your appendix, gallbladder, thyroid or tonsils removed?

Hormones

1). Any sleep disturbances?

2). When you wake up in the morning do you feel energized or do you feel you want to sleep longer?

3). Do you feel tired regardless the amount of hours you sleep?

4). Do you get cravings for sugar OR salt? Please specify

5). Do you have difficulty losing and/or gaining weight regardless of diet/exercise regimen you follow?

Thyroid

1). Do you get cold hands/feet?

2). Do you easily gain weight?

3). Do you experience constipation?

4). Do you have history of high cholesterol?

Oestrogen*(for Females)*

1). Have you ever been diagnosed with PCOS? Fibroids? Endometriosis?

2) Do you have periods? Are you menopausal?

3) Are you taking HRT?

4). Do you have history of migraines?

5). Do you experience hair loss? Low sex drive? Hot flushes?

6). Have you experienced irregular menstrual cycles?

7) Are you getting hair in unwanted places, face, chin, body?

Blood sugar

1). Have you ever been diagnosed with diabetes?

2). Do you frequently get thirsty?

3). Do you frequently feel the urge to urinate?

4). Do you feel tired/fatigued after a meal? OR Do you feel energized after a meal?

5). Do you feel "hangry" in the morning before breakfast? (Hungry and angry)

Testosterone *(for Males)*

1). Do you urinate frequently and/or have difficulty urinating?

2). Do you suffer from baldness?

3). Do you have difficulty gaining muscle weight when working out?

4). Do you have difficulty losing weight?

5). Do you experience low sex drive?

Digestion

1). Do you experience gas and/or bloating after eating?

2). Have you taken pro-biotics and did they help?

3). Have you been diagnosed with stomach ulcers or gastritis? SIBO (Small Intestinal Bacterial Overgrowth)? Candida? Depression? ADHD?

4). Do you experience skin itching/irritation frequently?

5). Have you recently been experiencing food sensitivity/allergies to food not previously experienced?

6). Do you have any skin conditions? (i.e. psoriasis, eczema, rosacea, hives, acne, etc.)

7) Do you tolerate alcohol badly?

8) Have you tried Kombucha tea?

General

1). List of supplements

a). What do you take them for?

b). Do they help you with your symptoms?

Thank you for taking the time to fill in the form.  If you could send it back for the attention of Dan at eastbourneosteopaths@gmail.com  in advance of our appointment so I can start working on your timeline it would be much appreciated.

I look forward to seeing you soon

Warmest regards, Dan