

National Council for



Osteopathic Research

Standardised Data Collection Questionnaire Patient Information– Version 2.0 SDC

Part 1: Initial consultation for new episode <i>To be completed by the osteopath</i>	
Practitioner ID code 1. Date of first appointment	2. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
3. Postcode: <i>Please state first part only e.g. SE11, BN20</i>	4. Patient's age (years)
5. Patient's height Metres and cms* Feet and inches* *Circle as appropriate	6. Patient's weight Kg and g* Stone and lbs* *Circle as appropriate
7. What is the patient's main occupation? Not applicable <input type="checkbox"/>	8. How would you describe the patient's current work status? <i>(tick as appropriate)</i> <input type="checkbox"/> Working full time (employed) <input type="checkbox"/> Working full time (self-employed) <input type="checkbox"/> Working part time (employed) <input type="checkbox"/> Working part time (self-employed) <input type="checkbox"/> Not currently employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Pre-school
9. Does the patient receive disability allowance? Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>	
10. How physically demanding is the patient's occupation? <input type="checkbox"/> strenuous <input type="checkbox"/> sedentary <input type="checkbox"/> moderate <input type="checkbox"/> not applicable <input type="checkbox"/> light	11. How strenuous are the patient's leisure time activities? (see examples below) <input type="checkbox"/> strenuous <input type="checkbox"/> sedentary <input type="checkbox"/> moderate <input type="checkbox"/> not applicable <input type="checkbox"/> light
EXAMPLE LEISURE ACTIVITIES Sedentary: handicrafts, cinema Light: badminton, bowling, light gardening, walking (including to and from shops) Moderate: jogging, swimming, moderate gardening Strenuous: basketball, competitive cycling, competitive swimming, football, squash, heavy gardening	
12. Who referred the patient to this practice? <input type="checkbox"/> patient <input type="checkbox"/> GP <input type="checkbox"/> insurance company <input type="checkbox"/> employer <input type="checkbox"/> NHS Consultant <input type="checkbox"/> solicitor <input type="checkbox"/> another healthcare practitioner	13. Has the patient ever had any osteopathic treatment before? <input type="checkbox"/> yes <input type="checkbox"/> no

14. How did the patient hear about this practice?
(tick all that apply)

- Word of mouth/recommendation
- Local advert
- Yell.com
- Yellow pages
- Thompson Directory
- I live nearby
- From a healthcare practitioner
- Internet search
- Other, please specify

15. Why did the patient decide to have osteopathy?
(tick all that apply)

- Personal recommendation or referral
- Personal research
- Waiting for NHS physio appointment
- Failure of previous treatment
- Previous experience of osteopathic treatment
- Desire to have osteopathic treatment
- Wanted a form of manual or hands on treatment
- Did not want treatment through the NHS
- Wanted to have drug-free treatment
- Other, please specify

16. How long did the patient have to wait for the <u>first appointment</u> to be offered? <input type="checkbox"/> Same day <input type="checkbox"/> 2-3 days <input type="checkbox"/> 4-7 days <input type="checkbox"/> 8 days or more																																																			
17. Is the patient on an NHS waiting list for treatment for this condition? <input type="checkbox"/> yes <input type="checkbox"/> no	18. How long has the patient been waiting for NHS treatment for this condition? _____Weeks Not applicable <input type="checkbox"/>																																																		
19. How many times has the patient visited their GP about this condition prior to coming to here? <i>times</i>																																																			
20. How many weeks has the patient had this current problem? <input type="checkbox"/> less than 1 week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 3-4 weeks <input type="checkbox"/> 5-6 weeks <input type="checkbox"/> 7-12 weeks <input type="checkbox"/> 13-51 weeks <input type="checkbox"/> 1 year or more	21. How many weeks has the patient been off work with this current problem? <input type="checkbox"/> less than 1 week <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> 3 weeks <input type="checkbox"/> 4 weeks <input type="checkbox"/> 5 weeks or more <input type="checkbox"/> not applicable																																																		
22. Has the patient had previous treatment or investigations for <u>this</u> episode of this condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, has this included: <i>Tick all that apply</i>																																																			
Imaging e.g. an X-Ray or scan Blood test Medication Urinalysis Hospital outpatient treatment Hospital inpatient treatment Other (please state)	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; padding-right: 20px;">NHS</td> <td style="text-align: center;">Private</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	NHS	Private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
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23. Type of onset of symptoms? <i>Tick all that apply</i> <input type="checkbox"/> Acute/sudden onset (of unknown origin) <input type="checkbox"/> Traumatic onset (of known origin) <input type="checkbox"/> Slow/insidious onset <input type="checkbox"/> Recurring problem	24. Is this the first episode? <i>Please tick</i> <input type="checkbox"/> Yes, first time onset <input type="checkbox"/> Second episode <input type="checkbox"/> Third episode <input type="checkbox"/> Fourth or more episodes																																																		
25. Severity of main symptoms on first visit – for patient completion																																																			
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26. Symptom areas: Please record up to four predominant symptom areas in order of priority for the patient

1st 2nd 3rd 4th

- | | | |
|----------------------|----------------------------|----------------|
| 1 Head/facial area | 9 Hand | 17 Knee |
| 2 Temporo-mandibular | 10 Thoracic spine | 18 Lower leg |
| 3 Neck | 11 Rib cage | 19 Ankle |
| 4 Shoulder | 12 Lumbar | 20 Foot |
| 5 Upper arm | 13 Sacroiliac/pelvis/groin | 21 Abdomen |
| 6 Elbow | 14 Gluteal region | 22 Other |
| 7 Forearm | 15 Hip | |
| 8 Wrist | 16 Thigh/upper leg | |

27. What current co-existing conditions (diagnosed by a medical practitioner) does the patient have (tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina | <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) |
| <input type="checkbox"/> CHF (Congestive heart failure) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> MI (myocardial infarct) | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Stroke/TIA (Transient Ischaemic Attack) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Bowel disease |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Upper gastrointestinal disease |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Other (please state) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> None |
| <input type="checkbox"/> Osteoporosis | |

Part 2: Management and treatment

28. What treatment plan was agreed with the patient?

- | | |
|--|---|
| <input type="checkbox"/> Osteopathic management | <input type="checkbox"/> Single consultation only |
| <input type="checkbox"/> Non-osteopathic treatment | <input type="checkbox"/> Patient referred on |

29. What types of treatment approaches have been used with the patient today?

- | | |
|---|--|
| <input type="checkbox"/> No hands on treatment | <input type="checkbox"/> Education |
| <input type="checkbox"/> Soft tissue | <input type="checkbox"/> Relaxation advice |
| <input type="checkbox"/> Articulation | <input type="checkbox"/> Steroid Injection |
| <input type="checkbox"/> HVLA thrust | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Cranial techniques | <input type="checkbox"/> Dietary advice |
| <input type="checkbox"/> Muscle energy | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Strain/counterstrain | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Functional technique | <input type="checkbox"/> Lifestyle advice |
| <input type="checkbox"/> Visceral | <input type="checkbox"/> Other (please name) |
| <input type="checkbox"/> Myofascial release (MFR) | |

Part 3: Information and Consent
(this information will be treated in strict confidence)

30. How was consent gained for examination?

- Implied consent
- Verbally
- Written
- Written and verbal
- Not applicable
- Other

31. How was consent gained for treatment?

- Implied consent
- Verbally
- Written
- Written and verbal
- Not applicable
- Other

32. Were any of the following procedures conducted and was specific consent obtained?

	Conducted		Consented		N/A
	Yes	No	Yes	No	
Per rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Per vaginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical HVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar HVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic HVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Did you discuss with the patient

	Yes	No	N/A
Treatment options for their problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Possible risks and side effects of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The anticipated response to treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The anticipated number of treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ways to avoid recurrences in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An explanation of the presenting problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. What self-management strategies have been recommended for the patient to use?

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Vitamins or other nutritional supplements |
| <input type="checkbox"/> Application of heat | <input type="checkbox"/> Use of Back Book |
| <input type="checkbox"/> Application of cold | <input type="checkbox"/> Use of Whiplash Book |
| <input type="checkbox"/> Contrast bathing | <input type="checkbox"/> Natural remedies |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Naturopathic neuromuscular techniques |
| <input type="checkbox"/> Specific exercise | <input type="checkbox"/> Relaxation advice |
| <input type="checkbox"/> General exercise | <input type="checkbox"/> Advice concerning physical activity |
| <input type="checkbox"/> Other (please state) | |

35. Who is responsible for payment for treatment

- Self
- Insurance company
- Employer/own company
- Referral by NHS
- Other (please state)

36. Is an insurance case or litigation claim pending?

Yes No

37. Time allocated for first appointment

_____ minutes

Part 4. Second appointment

38. After the first appointment, did the patient report any complications of treatment within the first 48 hours?

- None of these
- Increased pain
- Increased stiffness
- Dizziness
- Nausea
- Headache
- Fatigue
- Serious adverse event, if known, please describe below

39. What was the patient's overall outcome after the first appointment?

- Worst ever
- Much worse
- Worse
- Not improved/not worse
- Improved
- Much improved
- Best ever

40. What types of treatment approaches have been used with the patient? *Please tick all that apply*

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> No hands on treatment <input type="checkbox"/> Soft tissue <input type="checkbox"/> Articulation <input type="checkbox"/> HVLA thrust <input type="checkbox"/> Cranial <input type="checkbox"/> Muscle energy <input type="checkbox"/> Strain/counterstrain <input type="checkbox"/> Functional <input type="checkbox"/> Visceral | <ul style="list-style-type: none"> <input type="checkbox"/> Education <input type="checkbox"/> Relaxation advice <input type="checkbox"/> Steroid Injection <input type="checkbox"/> Acupuncture <input type="checkbox"/> Dietary advice <input type="checkbox"/> Exercise <input type="checkbox"/> Orthotics <input type="checkbox"/> Myofascial release (MFR) <input type="checkbox"/> Other (please name) |
|--|---|

41. What self-management strategies have been recommended for the patient to use? *Please tick all that apply*

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Application of heat <input type="checkbox"/> Application of cold <input type="checkbox"/> Contrast bathing <input type="checkbox"/> Rest <input type="checkbox"/> Specific exercise <input type="checkbox"/> General exercise <input type="checkbox"/> Other (please state) | <ul style="list-style-type: none"> <input type="checkbox"/> Vitamin or other nutritional supplements <input type="checkbox"/> Use of the Back book <input type="checkbox"/> Use of the Whiplash book <input type="checkbox"/> Natural remedies <input type="checkbox"/> Naturopathic neuromuscular techniques <input type="checkbox"/> Relaxation advice <input type="checkbox"/> Advice concerning physical activity |
|---|--|

42. Time allocated for follow up appointments minutes

Part 5: Last visit of initial course of treatment for this episode

43. Date of final visit:

44. Total number of treatments for this episode to date:

45. Has the patient completed the initial course of treatment for this episode?

- Yes
 No, treatment is ongoing
 Patient did not return (reason unknown)
 Treatment terminated due to illness
 Treatment terminated due to finance
 Treatment terminated for other reason (please state)

46. Severity of main symptoms on last visit – for patient completion

	0	1	2	3	4	5	6	7	8	9	10	
Best imaginable	<input type="checkbox"/>	----	<input type="checkbox"/>	----	<input type="checkbox"/>	----	<input type="checkbox"/>	----	<input type="checkbox"/>	----	<input type="checkbox"/>	Worst imaginable
					Moderate							

<p>47. Is the patient <u>continuing</u> to report any complications of treatment</p> <ul style="list-style-type: none"> <input type="checkbox"/> None of these <input type="checkbox"/> Increased pain <input type="checkbox"/> Increased stiffness <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Headache <input type="checkbox"/> Fatigue <input type="checkbox"/> Serious adverse event, if known, please describe 	<p>48. What was the patient's overall outcome at their final appointment or to date?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Worst ever <input type="checkbox"/> Much worse <input type="checkbox"/> Worse <input type="checkbox"/> Not improved/not worse <input type="checkbox"/> Improved <input type="checkbox"/> Much improved <input type="checkbox"/> Best ever 						
<p>49. How many treatments did the patient have before being able to return to work? </p> <p><input type="checkbox"/> Not applicable (retired) <input type="checkbox"/> Not applicable (not off work) <input type="checkbox"/> Not applicable (not able to return to work)</p>							
<p>50. Did you contact the patient's GP during this course of treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reasons for contact</p> <ul style="list-style-type: none"> <li style="width: 50%;"><input type="checkbox"/> Patient was referred by the practice <li style="width: 50%;"><input type="checkbox"/> GP had requested information <li style="width: 50%;"><input type="checkbox"/> To request further information or investigation <li style="width: 50%;"><input type="checkbox"/> To request referral for other treatment <li style="width: 50%;"><input type="checkbox"/> Other (please specify) <li style="width: 50%;"><input type="checkbox"/> To provide the GP with information 							
<p>51. At the last treatment, what was agreed for the patient's future care?</p> <ul style="list-style-type: none"> <input type="checkbox"/> None planned. Patient was discharged <input type="checkbox"/> Patient opted to return for episodic care <input type="checkbox"/> Patient awaiting results of investigation <input type="checkbox"/> Patient was referred on for investigation/treatment <input type="checkbox"/> Still continuing initial course of treatment <input type="checkbox"/> Patient planning to return for further treatment <input type="checkbox"/> Other (please state) 	<p>52. If the patient was referred on from your practice, where were they referred to?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Their GP <input type="checkbox"/> Other medical consultant <input type="checkbox"/> Other practitioner (please state) 						
<p>53. If the patient was referred for other treatment while still having osteopathic treatment, where were they referred to?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Their GP <input type="checkbox"/> Other medical consultant <input type="checkbox"/> Other complementary practitioner <input type="checkbox"/> Physiotherapist or podiatrist <input type="checkbox"/> A counsellor <input type="checkbox"/> Exercise trainer or class <input type="checkbox"/> Other (please state) 							
<p>54. To which ethnic group does the patient belong? (this question is optional: the information is intended to try and serve all groups equally)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <p>White</p> <ul style="list-style-type: none"> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background, please record </td> <td style="width: 33%; vertical-align: top;"> <p>Asian or Asian British</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background, please record </td> <td style="width: 33%; vertical-align: top;"> <p>Chinese or other ethnic group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other, please record </td> </tr> <tr> <td style="vertical-align: top;"> <p>Mixed</p> <ul style="list-style-type: none"> <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other Mixed background, please record </td> <td style="vertical-align: top;"> <p>Black or Black British</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background, please record </td> <td></td> </tr> </table>		<p>White</p> <ul style="list-style-type: none"> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background, please record 	<p>Asian or Asian British</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background, please record 	<p>Chinese or other ethnic group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other, please record 	<p>Mixed</p> <ul style="list-style-type: none"> <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other Mixed background, please record 	<p>Black or Black British</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background, please record 	
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Thank you for completing this form

Statement of accreditation

“This standardised data collection tool has been produced by the National Council for Osteopathic Research (NCOR), and funded by the General Osteopathic Council (GOsC), the UK regulator of osteopaths. The intellectual property rights in the standardised data collection tool are jointly owned by the NCOR and the GOsC. The tool should be referenced in published work as: Fawkes CA, Leach CMJ, Mathias S, Moore AP. Standardised data collection tool for osteopathic practice. National Council for Osteopathic Research (UK) and General Osteopathic Council UK, 2009”.

