## SDC Data Collection Tool

### Part 1: Initial consultation for new episode

*To be completed by the osteopath*

Practitioner ID code

1. Date of first appointment

2. Sex: Male ☐ Female ☐

3. Postcode:
*Please state first part only e.g. SE11, BN20*

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 ☐

8. How would you describe the patient's current work status? *(tick as appropriate)*

☐ Working full time (employed)
☐ Working full time (self-employed)
☐ Working part time (employed)
☐ Working part time (self-employed)
☐ Not currently employed
☐ Retired
☐ Student
☐ Pre-school
☐ Other, please specify

9. Does the patient receive disability allowance?

Yes ☐ No ☐ Not applicable ☐

10. How physically demanding is the patient's occupation?

☐ strenuous
☐ moderate
☐ light
☐ sedentary
☐ not applicable

11. How strenuous are the patient's leisure time activities? (see examples below)

☐ strenuous
☐ moderate
☐ light
☐ sedentary
☐ not applicable

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?

☐ patient
☐ insurance company
☐ NHS Consultant
☐ another healthcare practitioner
☐ GP
☐ employer
☐ solicitor

13. Has the patient ever had any osteopathic treatment before?

☐ yes ☐ 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 physiotherapy 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

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16. How long did the patient have to wait for the first appointment to be offered?
☐ Same day ☐ 2-3 days ☐ 4-7 days ☐ 8 days or more ☐ Not known

17. Is the patient on an NHS waiting list for treatment for this problem?

☐ yes ☐ no

18. How long has the patient been waiting for NHS treatment for this problem?

_____Weeks Not applicable ☐

19. How many times has the patient visited their GP about this problem prior to coming to here? *times*

20. How many weeks has the patient had this current problem?

☐ less than 1 week
☐ 1-2 weeks
☐ 3-4 weeks
☐ 5-6 weeks
☐ 7-12 weeks
☐ 13-51 weeks
☐ 1 year or more

21. How many weeks has the patient been off work with this current problem?

☐ less than 1 week
☐ 1 week
☐ 2 weeks
☐ 3 weeks
☐ 4 weeks
☐ 5 weeks or more
☐ not applicable

22. Has the patient had previous treatment or investigations for this episode of this problem?

Yes ☐ No ☐ If yes, has this included: *Tick all that apply*

| | NHS | Private |
|---|---|---|
| Imaging e.g. an X-Ray or scan | ☐ | ☐ |
| Blood test | ☐ | ☐ |
| Medication | ☐ | ☐ |
| Urinalysis | ☐ | ☐ |
| Hospital outpatient treatment | ☐ | ☐ |
| Hospital inpatient treatment | ☐ | ☐ |
| Other (please state) | ☐ | ☐ |

23. Type of onset of symptoms? *Tick all that apply*

☐ Acute/sudden onset (of unknown origin)
☐ Traumatic onset (of known origin)
☐ Slow/insidious onset
☐ Recurring problem

24. Is this the first episode? *Please tick*

☐ Yes, first time onset
☐ Second episode
☐ Third episode
☐ Fourth or more episodes

25. Severity of main symptoms on first visit – for patient completion

| No symptoms | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst imaginable symptoms |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | | | | | | Moderate | | | | | | |

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)

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

## Part 2: Management and treatment

28. What treatment plan was agreed with the patient?

- ☐ Osteopathic management
- ☐ Non-osteopathic treatment
- ☐ Single consultation only
- ☐ Patient referred on

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

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

## 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 | | |
|---|---|---|---|---|---|
| | Yes | No | Yes | No | N/A |
| Per rectal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Per vaginal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Oral | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cervical HVT | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lumbar HVT | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thoracic HVT | ☐ | ☐ | ☐ | ☐ | ☐ |

33. Did you discuss with the patient

| | Yes | No | N/A |
|---|---|---|---|
| Treatment options for their problem? | ☐ | ☐ | ☐ |
| Possible risks and side effects of treatment | ☐ | ☐ | ☐ |
| The anticipated response to treatment | ☐ | ☐ | ☐ |
| The anticipated number of treatments | ☐ | ☐ | ☐ |
| Ways to avoid recurrences in the future? | ☐ | ☐ | ☐ |
| An explanation of the presenting problem? | ☐ | ☐ | ☐ |

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

- ☐ None
- ☐ Application of heat
- ☐ Application of cold
- ☐ Contrast bathing
- ☐ Rest
- ☐ Specific exercise
- ☐ General exercise
- ☐ Other (please state)
- ☐ Vitamins or other nutritional supplements
- ☐ Use of Back Book
- ☐ Use of Whiplash Book
- ☐ Natural remedies
- ☐ Naturopathic neuromuscular techniques
- ☐ Relaxation advice
- ☐ Advice concerning physical activity

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
- ☐ Drowsiness
- ☐ 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*

- ☐ No hands on treatment
- ☐ Soft tissue
- ☐ Articulation
- ☐ HVLA thrust
- ☐ Cranial techniques
- ☐ Muscle energy
- ☐ Strain/counterstrain
- ☐ Functional
- ☐ Visceral
- ☐ Education
- ☐ Relaxation advice
- ☐ Steroid Injection
- ☐ Acupuncture
- ☐ Dietary advice
- ☐ Exercise
- ☐ Orthotics
- ☐ Myofascial release (MFR)
- ☐ Other (please name)

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

- ☐ None
- ☐ Application of heat
- ☐ Application of cold
- ☐ Contrast bathing
- ☐ Rest
- ☐ Specific exercise
- ☐ General exercise
- ☐ Other (please state)
- ☐ Vitamin or other nutritional supplements
- ☐ Use of the Back book
- ☐ Use of the Whiplash book
- ☐ Natural remedies
- ☐ Naturopathic neuromuscular techniques
- ☐ Relaxation advice
- ☐ 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No symptoms | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Worst imaginable symptoms |
| | | | | | | Moderate | | | | | | |

47. Is the patient <u>continuing</u> to report any complications of treatment

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

48. What was the patient's overall outcome at their final appointment or to date?

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

49. How many treatments did the patient have before being able to return to work? ☐

☐ Not applicable (retired) ☐ Not applicable (not off work) ☐ Not applicable (not able to return to work)

50. Did you contact the patient's GP during this course of treatment?

☐ Yes ☐ No If yes, reasons for contact

- ☐ Patient was referred by the practice
- ☐ To request further information or investigation
- ☐ Other (please specify)
- ☐ GP had requested information
- ☐ To request referral for other treatment
- ☐ To provide the GP with information

51. At the last treatment, what was agreed for the patient's future care?

- ☐ None planned. Patient was discharged
- ☐ Patient opted to return for episodic care
- ☐ Patient awaiting results of investigation
- ☐ Patient was referred on for investigation/treatment
- ☐ Still continuing initial course of treatment
- ☐ Patient planning to return for further treatment
- ☐ Other (please state)

52. If the patient was referred on from your practice, where were they referred to?

- ☐ Their GP
- ☐ Other medical consultant
- ☐ Other practitioner (please state)

53. If the patient was referred for other treatment while still having osteopathic treatment, where were they referred to?

- ☐ Their GP
- ☐ Other medical consultant
- ☐ Other complementary practitioner
- ☐ Physiotherapist or podiatrist
- ☐ A counsellor
- ☐ Exercise trainer or class
- ☐ Other (please state)

54. To which ethnic group does the patient belong? (this question is optional: the information is intended to try and serve all groups equally)

White
- ☐ British
- ☐ Irish
- ☐ Any other White background, please record

Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed background, please record

Asian or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background, please record

Black or Black British
- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, please record

Chinese or other ethnic group
- ☐ Chinese
- ☐ Any other, please record

***Thank you for completing this form***

## Statement of accreditation

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