

New Patient Form

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | | Surname | |
| Address | | Town | |
|  | | Postcode | |
| Home Ph | Work Ph | | Mobile |
| Date of Birth | | Email | |
| Occupation | | Marital Status | |
| Type of work: Active/Sedentary Heavy/Light Hours of driving Other? | | | |
| Children? | | Referred by? | |
| How did you hear about us? | | | |

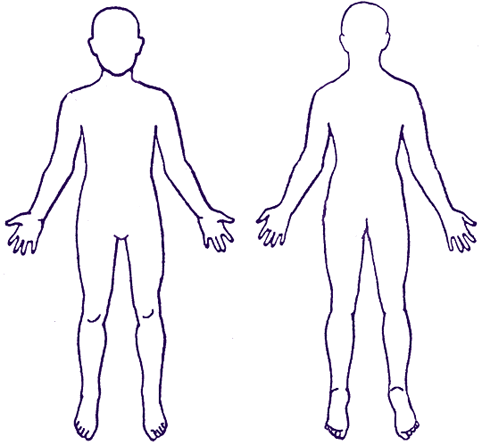
Please give a brief description of your reason for visiting us, including severity and duration.

1.

2.

3.

Please mark all problem areas on this diagram.



Please circle the terms below that best describes your pain.

Burning Dull Ache

Throbbing Numb Tingling

Progressively Worse Comes & Goes

Shooting Worst pain ever

Staying the same Getting better

What aggravates your condition?

What relieves your condition?

Have you ever had this type of pain before?

What do you think has caused your condition?

Please circle if you have had any of the following:

Frequent colds / infections/ Poor concentration /Headaches / Migraines / Arthritis/ Cold hands / feet Low energy fatigue/ Menstrual pain / Digestive problems /Bladder problems/ Hot flushes / fevers Heart disease/ Anxiety / Nervousness /Irritability /Allergies /Stroke/ Ulcers /Depression /Mood swings /Diabetes/ High blood pressure /Low pain threshold /Seizures / Fainting/ Respiratory problems/ Low back pain/ Neck pain/ Dizziness /Cancer

Have you ever been to a Chiropractor before? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen another therapist about your condition? If so who and what was the outcome?

Name and address of current GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list any operations you have had (and ages):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any serious illnesses you have had (and ages):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any traumas, accidents, broken bones or injuries you have had (and ages):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking medication (including the contraceptive pill)? If yes, what type and what for?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No

If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for how many years?\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? Units/week

Females Only: Is there any possibility that you are pregnant? Yes No

Date of last period: \_\_\_ / \_\_\_ / \_\_\_\_

Has any blood relative (not including your spouse) had any of the following. If yes, please specify (who, what, when):

Bone or Joint disease (Arthritis / Osteoporosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vascular disease (Heart disease / Stroke / Blood Pressure) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (Benign / Malignant) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory problems (Lung / Chest / Asthma) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestive problems (Stomach / Bowel) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reproductive problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes / Metabolic disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy / Nervous system disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give a brief description of your eating habits.

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, heat/ ice application, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

DECLARATION: This information is accurate to the best of my knowledge.

PATIENT…………………………………………SIGNATURE: .............................................. DATE: ….../……/……

CHIROPRACTOR SIGNATURE: ………………………………………………….... DATE: …../……/…….