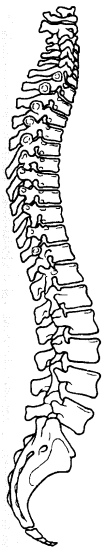
Complete Chiropractic Care

NEW PATIENT HISTORY



Mr/Mrs/Ms/Miss/Mst: Surname _____ First Name: _____

Occupation _____

Address _____ Suburb _____ P/C _____

Telephone (H) _____ (W) _____ (M) _____

Date of Birth _____ e-mail _____

Marital status _____ Partners' name _____

Number & names of children _____

Name & Location of G.P _____

How did you find out about us? _____

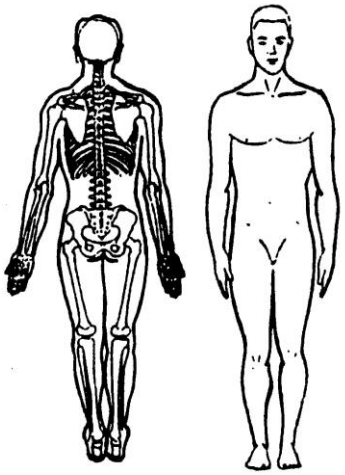
Have you visited a chiropractor before? Y/N _____

Do you participate in any physical activities? _____

What is your major complaint? _____

_____

PLEASE ILLUSTRATE AFFECTED AREAS



How long have you had this condition? _____

How did this happen? _____

Describe the nature of the pain (eg. Deep, dull, sharp, numb, pins and needles, etc)

_____

Is this condition becoming better or worse? _____

What aggravates the pain? _____

What makes it better? _____

Have you had any treatment for this condition, including medication? _____

_____

What position do you sleep in? (Please **Circle**) Stomach Side Back

Have you ever had any of the following? If yes, please give details (use back of sheet if necessary)

- Major illnesses _____
- Accidents _____
- Fractures/dislocations _____
- Surgery/hospitalisations _____
- Medication/drugs _____
- Alcohol/tobacco _____

Have you ever had spinal x-rays? When? For what reason? _____

_____

Are you pregnant? Y/N If yes, how advanced _____

Do you suffer from any other condition or is there anything else you would like the Chiropractor to know? _____

_____

Please **TICK** any condition you currently have or place a **CROSS** if you have had a condition in the past:

Headaches ☐	Depression ☐	Low Blood Pressure ☐	Prostate Trouble ☐
Neck Pain ☐	Constipation ☐	Poor Circulation ☐	Chest Pain ☐
Upper Back Pain ☐	Diarrhoea ☐	Bruising Easily ☐	Heart Disease ☐
Mid Back Pain ☐	Poor Digestion ☐	Diabetes ☐	High Blood Pressure ☐
Low Back Pain ☐	Liver Problems ☐	Stroke ☐	Chronic Cough ☐
Shoulder Pain ☐	Nausea ☐	Cancer ☐	Difficulty Breathing ☐
Elbow or Wrist Pain ☐	Vomiting ☐	Asthma ☐	Poor Sleep ☐
Hip, Knee or Ankle Pain ☐	Poor Appetite ☐	Sinusitis ☐	Tiredness ☐
Arthritis ☐	Painful Menstruation ☐	Ringing in the Ears ☐	Painful Urination ☐
Dizziness ☐	Infertility ☐	Difficulty Swallowing ☐	Kidney Infection ☐

What are your health goals through Chiropractic? (**please tick one or more**)

(a) Pain Relief ☐
(b) Increased mobility ☐
(c) Rehabilitation ☐
(d) Maintenance Wellness Care ☐
(e) Improved overall health and wellbeing ☐
(f) Other:_____ ☐

Health and Wellbeing

Please rate the following:

How would you rate the quality of your physical state?
Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

How would you rate the quality of your sleep?
Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

How would you rate your energy levels?
Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

How would you rate your stress levels?
Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

How would you rate your overall health?
Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

Signature: _____ Date: _____

File Number