NEW PATIENT FORM- ADULT (10 YEARS +)

Patient Details

Full Name: ______________________________ DOB: ____________ Male ☐ Female ☐
Address: ______________________________ Town: ______________
Postcode: ______________________
Occupation: ______________________
Phone M: ______________________ H: ______________________
Email: _

Status: Single ☐ Married ☐ Cohabitation☐ Widow ☐ Separated/Divorced ☐

Partners Name: ______________________ Any Children /Ages: ______________

How did you find out about our clinic? ______________________

Have you been to a Chiropractor before? Yes ☐ No ☐
Any other previous treatment? (E.g: Physio) ______________________
Is there any chance that you are pregnant: Yes ☐ No ☐

Private health insurance: No ☐ Yes ☐ Insurer ______________

GP Name & Medical Centre: ______________________
Permission to contact (if req) Yes ☐ No ☐

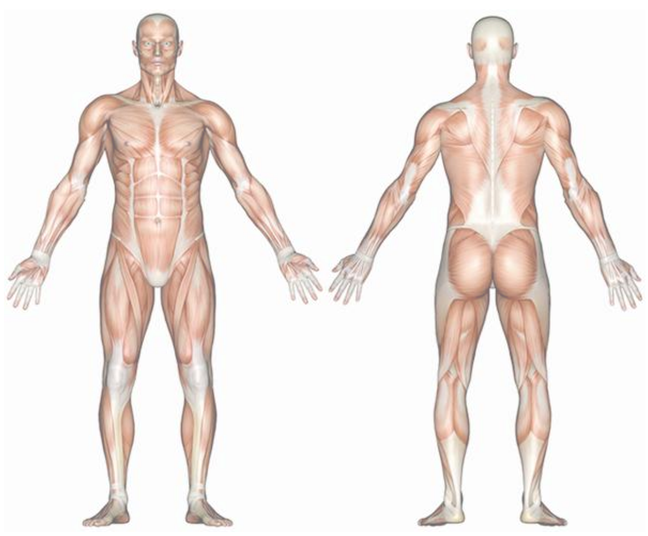
Health Questionnaire
Reason attending clinic:
-Optimal health / prevention ☐
-Specific health concern ☐

Reason for attending our clinic, in brief
____

When did this problem start:
-date ____________ **OR** ongoing condition ☐

Describe the pain:
☐on and off ☐always there
☐improving ☐staying the same ☐worsening
☐ sharp/shooting ☐dull aching ☐burning
☐ throbbing ☐numb/tingling ☐ other

Please mark any areas of concern below



Please circle the relevant level of Pain/General Health

Main Concern- Pain Level

1 2 3 4 5 6 7 8 9 10

General Health

1 2 3 4 5 6 7 8 9 10

Please list any:

1. Previous surgery_____

2. Significant trauma / injury / accidents _____

3. Medications (within the previous 6 months) _____

4. Significant illnesses or disability _____

GENERAL HEALTH QUESTIONNAIRE

Years of uncorrected spinal and nerve problems may lead to many different symptoms and body signals.
Please tick only the symptoms that apply to you:

(**O=Occasional symptoms** **F= Frequent symptoms**)

O F Head/Neck
- ☐ ☐ Headaches
- ☐ ☐ Light Headed
- ☐ ☐ Loss of Balance
- ☐ ☐ Hearing Loss
- ☐ ☐ Ringing in Ears
- ☐ ☐ Buzzing in Ears
- ☐ ☐ Neck Pain / Ache
- ☐ ☐ Grating / Cracking in neck

O F Shoulder, Arm, Fingers, Hands
- ☐ ☐ Pain
- ☐ ☐ Pins and Needles
- ☐ ☐ Numbness
- ☐ ☐ Weakness / Loss of strength
- ☐ ☐ Restricted movement
- ☐ ☐ Swollen Joints

O F Chest and abdomen
- ☐ ☐ Pain/ tightness in chest
- ☐ ☐Pain around ribs
- ☐ ☐Shortness of breath
- ☐ ☐Wheezing
- ☐ ☐ Rapid heartbeat
- ☐ ☐Thumping Heart beat
- ☐ ☐Stomach/Abdominal pain
- ☐ ☐Belching or excessive wind
- ☐ ☐ Nausea
- ☐ ☐Abdominal organ problems
- ☐ ☐ Constipation or diarrhea
- ☐ ☐ Hernia
- ☐ ☐Groin or pelvic pain

O F Low back, Legs or feet
- ☐ ☐ Pain
- ☐ ☐ Pins & needles
- ☐ ☐ Numbness
- ☐ ☐ Restriction of movement
- ☐ ☐ Swollen Joints

O F Geneto-Urinary System
- ☐ ☐ Urinary problems or infections
- ☐ ☐ Difficulty starting or stopping urination
- ☐ ☐ Loss of control or urination
- ☐ ☐ Bed wetting
- ☐ ☐ Prostate problems

O F Females Only
- ☐ ☐ Painful, tender or lumps in breasts
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Menstrual problems or abnormalities
- ☐ ☐ Painful intercourse

O F General symptoms
- ☐ ☐ Allergies, sinus problems etc.
- ☐ ☐ Excessive fatigue
- ☐ ☐ Chills, fever
- ☐ ☐ Fainting
- ☐ ☐Sudden, recent loss of weight
- ☐ ☐ Depression or mental illness
- ☐ ☐ Excessive sweating
- ☐ ☐Vascular disorders
- ☐ ☐High blood pressure (hypertension)
- ☐ ☐Low blood pressure

O F Neurological
- ☐ ☐Tremors
- ☐ ☐ Loss of balance
- ☐ ☐ History of stroke, TIA, thrombosis etc.
- ☐ ☐ History of cardiovascular disease

Please tick if **yourself (S) or Family (F)** have had the following:

S F
- ☐ ☐ Cancer
- ☐ ☐ Vascular of heart disease
- ☐ ☐ Arthritis or joint problems
- ☐ ☐ Neurological conditions
- ☐ ☐ Other serious illness
- ☐ ☐ Diabetes
- ☐ ☐ Other _____