New Patient Form

Dr Mac CHIROPRACTIC

SECTION A - Personal Details

Title: Mr Mrs Miss ___ **Full Name:** _____ **Date of birth:** _____ **Gender:** F M

Street Address: _____ **Suburb:** _____ **Post Code:** _____

Phone Numbers - home: _____ mobile: _____ work: _____ ext:_____

E-mail address:

Occupation: _____

How did you find out about us? (please circle): Referred Web Search Signage Social Media Other

_____

If referred whom should we thank for recommending you to us? _____

Name of your GP: _____ **GP Clinic** : _____

Have you had previous Chiropractic Care? (If Yes, who did you see and when was your last visit): _____

_____

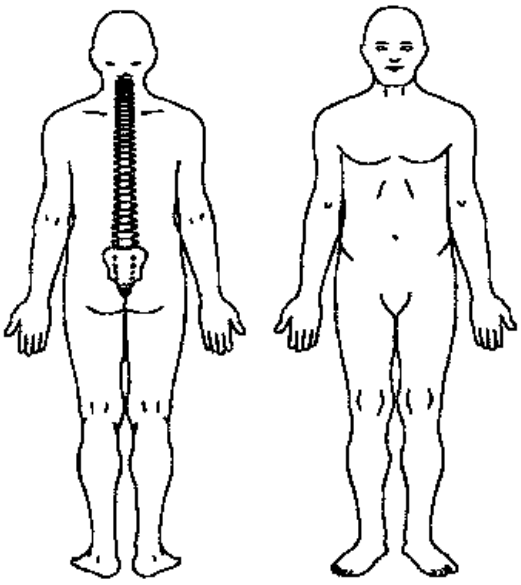
SECTION B – Main Complaint/Problem

What is your main complaint or problem area? (the reason for you being here day): _____

_____

_____

Please mark with a cross on the diagram the areas of your discomfort



On a scale of (1 to 10) rate your current pain level? 1 = a little sore 10 = unbearable pain

(please circle) **1 2 3 4 5 6 7 8 9 10**

How would you best describe the pain? (circle below):

Burning	Stabbing	Numbness
Aching	Tightness	Cramping
Throbbing	Tingerling	Radiating, or the pain travels

If, radiating where does the pain travel to? _____

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When did you first notice the problem, why do you think it started? _____

_____

Have you had this type of problem before? _____

Have you seen anyone else for this problem? (If Yes, please explain who you consulted and when):

_____

_____

Since the injury began has it been getting? (please circle): better worse staying the same

Does anything make the pain worse? _____

Does anything help relieve the pain? _____

Is it worse at any particular time? (please circle in the morning end of the day during/after sport

Other _____

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SECTION C – Current Health

Rate your current overall health: (please circle below) 1 = terrible 10 = fantastic

1 2 3 4 5 6 7 8 9 10

What are your current health goals on a scale: 1 = most important 4 = least important

Pain relief ___ Increased Performance ___ Rehabilitation ___ Improve Health/quality of life ___

Other (please specify) _____

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SECTION D – Illness History

Other than your main complaint do you have any other current health problems? _____

_____

Have you been treated for any health conditions in the last year? _____

_____

Have you ever had any operations – what for & when? _____

_____

Are you currently taking any medication, for? _____

_____

Have you ever had any serious accidents, what happened and when? _____

_____

Have you ever suffered from any major illnesses or conditions? _____

_____

Has any member of your family suffered from a serious disorder such as - diabetes, rheumatic conditions, cancer, heart conditions, etc? _____

_____

Have you ever suffered from any of the following conditions? (please circle all that apply to you):

Dizziness	Fatigue	Headaches	Loss of sleep
Pain at Night	Unexplained weight loss	Numbness	Arthritis
Asthma	Low back pain	Sciatica	Swollen Joints
High Blood pressure	Frequent Colds	Difficulty Breathing	Foot trouble
Low Blood pressure	Chest Pain	Poor circulation	Anemia
Stroke	Pleurisy	Aids	Frequent Urination
Prostate trouble	Lumps in breast	Diabetes	Cancer

Other _____

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