Function.*allied* Health

CHIROPRACTIC NEW PATIENT FORM

Today's Date: _____

Personal Details

Mr Mrs Miss Ms _____

Address: _____

Post Code: _____ Date of Birth: / / Number of Children: _____

Phone Number: (H) _____ (W) _____ Health Fund: _____

(M) _____ Email: _____

Occupation: _____ Partner's Name: _____

Emergency Contact: _____ Phone Number: _____

Medical Doctor: _____ Phone Number: _____

Referral Details

Who can we thank for referring you to us?

- ☐ Family/Friend: _____
- ☐ Chiropractic Association
- ☐ Health Fund
- ☐ Health Care Practitioner
- ☐ Social Media (Instagram)
- ☐ Social Media (Facebook)
- ☐ Website
- ☐ Signage/Drove past

Accidents/Injuries

Please list any accidents/injuries.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Health Details

Please check-off any medications you are taking and list any others.

- ☐ Pain Killers
- ☐ Muscle Relaxants
- ☐ Vitamins
- ☐ Anti-inflammatories
- ☐ Birth Control
- ☐ Blood Pressure
- ☐ Other(s): _____

_____

Please list any operations.

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any known medical conditions or allergies.

_____

_____

Flip Over

Please check-off any of the following that you suffer from.

- ☐ Headaches
- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Fatigue
- ☐ Depression
- ☐ Fever
- ☐ Shortness of Breath
- ☐ Loss of Smell
- ☐ Period Pain
- ☐ Constipation/Diarrhoea
- ☐ Fainting
- ☐ Chest Pain
- ☐ Numbness in Arms/Hands
- ☐ Cold Hands/Feet
- ☐ Cold Sweats
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Can'tFight Infections

What is the main reason you consulted this practice? _____

What was the cause? _____

When did the problem first start? _____

The problem is...

- ☐ Getting Worse
- ☐ Staying the Same
- ☐ Getting Better

It interferes with...

- ☐ Sport
- ☐ Home
- ☐ Sleep
- ☐ Recreation
- ☐ Work

Has somthing similar happened before?

- ☐ Yes
- ☐ No

Have you previously seen a Chiropractor?

- ☐ Yes Who? _____ Date: _____
- ☐ No

Was it for the same/a similar condition?

- ☐ Yes
- ☐ No

Have you seen any other health professional about this problem?

- ☐ Yes Who? _____ Date: _____
- ☐ No

Exercise/Sports Details

Outline any excercises or sports that you are currently participating in:

_____

_____

Is there anything else you would like to tell us?

_____

_____

_____

_____

Patient Signature (or Parent/Guardian): _____

Date: _____

Please return this form to reception.