NEW PATIENT FORM

BALANCED SPINE
CHIROPRACTIC

WELCOME

Name: Mr / Mrs / Ms / Miss (first)_____ (last)_____ (preferred)_____

Date of Birth: _____ **Occupation:** _____

Address: _____ **Postcode:** _____

Telephone: (home)_____ (work)_____ (mobile)_____

Email Address: _____

Next of Kin: (name)_____ **Contact Number:** _____

How did you hear about us (circle)
Referred by friend/family (name)_____ Expo/homeshow, Google, Facebook, Webpage

other (specify) _____

Name of GP & Contact Number: _____

MAIN CONCERN

What is the main purpose of your visit today? _____

_____

Have you had this problem before? _____

Does anything help relieve it? _____

Does anything make it worse? _____

When did you first notice the problem? _____

Is it worse at any particular time? (eg. day or night) _____

Has it been getting better / worse / staying the same? _____

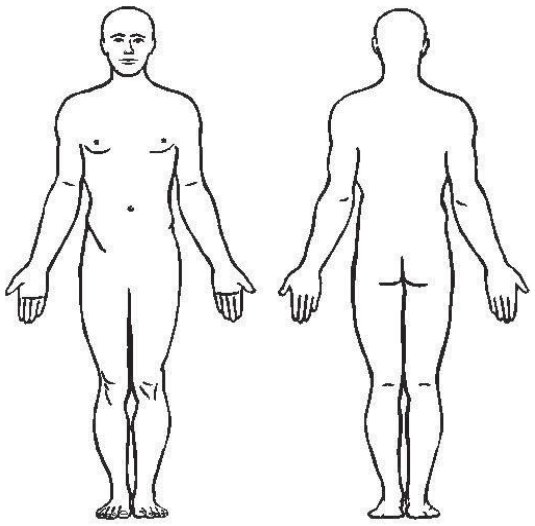
Have you had previous Chiropractic care? Yes / No Please detail if you like _____

Are you under the care of any other health professional? _____

If Yes, please specify: _____

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

Scale of 1-10 of pain level for each mark on diagram
(1-slight pain 10 - unbearable pain)



LIFESTYLE / HISTORY

Stress on the body can affect other areas of your life. How would you rate your current stress level?

☐ very low ☐ low ☐ moderate ☐ high ☐ very high

How would you rate your sleep?

☐ poor ☐ unsettled/broken ☐ adequate ☐ good ☐ great

How would you describe your energy levels?

☐ poor ☐ average ☐ OK/satisfactory ☐ good ☐ great

Does your typical day involve any of the following?

☐ heavy lifting ☐ long periods of driving ☐ repetitive movements ☐ frequent bending
☐ vigorous activity ☐ long periods of computer work ☐ shift work

How would you describe your posture? (ie. hunched, normal, weak, lopsided) _____

Are you or have you been on any long-term medication? If yes, what? _____

Have you been hospitalised or had surgery? If Yes, why and when? _____

Have you ever suffered a heart attack, stroke or been diagnosed with cancer? If Yes, please specify? _____

_____

Do you have a family history of heart attacks, stroke, cancer or autoimmune disease? If Yes, please explain?

_____

Have you experienced any major accidents/traumas to your body? _____

_____

In the past few months have you experienced any of the following?

☐ unexplained changes in weight ☐ sores that wont heal ☐ numbness/tingling in limbs upper / lower
☐ change in bowel/bladder function ☐ nagging cough ☐ headaches/migraines
☐ unexplained night sweats ☐ pain at night ☐ depression/anxiety
☐ dizziness/vertigo ☐ trouble sleeping ☐ irritability or anger

Do you have any other health concerns or known illnesses? If Yes, what? _____

Is there any further information you would like us to know?_____

_____

What would you rate your current level of health? 1 poor, 10 great _____

How often do you exercise? _____**What level of actively is it?**_____

Do you play any sport? _____

How many glasses of water do you drink per day? _____

Do you drink: ☐ **soft / fizzy drink** ☐ **coffee** ☐ **energy drinks** ☐ **tea**

Do you smoke? ☐ **Yes** ☐ **No**

How many units of alcoholic beverages do you consume a week? _____

AUTHORISATION FOR CARE

As with all health care professionals, the law now requires practitioners who adjust the spine, to inform patients of material risk. Chiropractic adjustments of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and many other alternatives. (A risk assessment of cervical manipulation, JMPT, 1995, Magna Report, Ontario Ministry of Health, 1993.)

In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke-like symptoms. This is extremely rare, occurring in approximately 1 in 5.85 million (Haldeman, et al. Spine, 1991, Vol 24-8.)

If you have any questions related to the care you are about to receive, please speak to the chiropractor.

Please sign below if you give permission for the chiropractor to examine and administer care as deemed necessary. For patients under the age of 18, a parental guardian must sign below.

Signature: _____ Date: _____