LIFETIME FAMILY WELLNESS CENTRES
WELLNESS ...A Lifestyle for a Lifetime

NEW PATIENT QUESTIONNAIRE

(STRICTLY CONFIDENTIAL)

ADULT **Date_____**

Personal Details

Mr/Mrs/Miss/Ms_____
Given Name Middle Name Surname

Address_____

_____Post Code_____

Telephone:(Home)_____(Mobile)_____(Work)_____

(Email)_____

DO YOU WISH TO RECEIVE OUR MONTHLY NEWSLETTER TO YOUR EMAIL? ☐ YES ☐ NO

Date of Birth: / / Age: ____ Number of Children ___ Partners Name _____

Occupation: _____

Person Responsible for Accounts:_____ Health Fund:_____

Referral Details

WHO CAN WE THANK FOR REFERRING YOU TO US:

Family/Friend (name)_____Yellow Pages ___Saw Sign ___Voucher _____Local Paper___

Health Fund_____Chiropractic Association_____Health Care Practitioner ___Spinal Care Class ___Other_____

Accidents or Injuries

LIST ANY ACCIDENTS OR INJURIES: Date:

_____ _____

_____ _____

Your Medical Doctor is_____Phone Number:_____

Health Details

LIST ANY MEDICATIONS CURRENTLY TAKEN: ___Pain Killers ___Muscle Relaxants ___Anti-Inflammatory

_____Birth Control ___Blood Pressure ___Vitamins Please list any other:_____

_____

List any operations: Date:

_____ _____

Do you suffer from any of the following:(*Please tick*)

___Headaches ___Shortness of Breath ___Numbness in Arms/Hands ___Cold Hands/Feet

___Neck Pain/Stiffness ___Loss of Smell ___Cold Sweats ___Fatigue ___Period Pain

___Back Pain/Stiffness ___Depression ___Dizziness ___Fainting ___Fever___

___Sleeping Difficulty ___Chest Pain ___Can't fight infection ___Constipation/Diarrhoea

Which of the above is the main reason you have consulted this practice:_____

What was the cause:_____

When did the problem commence_____

Is the problem:(Please Circle) 1. Getting Worse 2. Staying the Same 3. Getting Better

Have you had a similary case before Yes No

Does it interfere with (please circle) 1. Sport 2. Home 3. Sleep 4. Recreation 5. Work

Have you previously seen a chiropractor:

Yes (Who)_____ Date_____

No ____

If yes was it for a similar condition: (please circle)

Yes No

Have you seen any other health professional about this problem:-

Yes (Who) _____ Date_____

No ____

Exercise/ Sports Activities

PLEASE OUTLINE ANY EXERCISES OR SPORTS THAT YOU ARE CURRENTLY PARTICIPATING IN:

_____
_____
_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US:

_____
_____
_____
_____

LIFETIME WELLNESS

CONSENT FORM

Chiropractic Care, when performed by a qualified Chiropractor has been found to be both an effective and safe form of care for many health conditions. There are, however, risks associated with any treatment no matter how small, that you need to be informed of and we ask that you read the following carefully:

I understand there are very minimal risks resulting from treatment, such as but not limited to: muscle and joint soreness, sprain, muscle strain, disc injury, nerve irritation or damage.

I understand in extremely rare cases, some treatments to the neck may result in injury to blood vessels and give rise to stroke or stroke like symptoms. (approximately 1 in 5.85 million neck adjustment.)

I understand that results are not guaranteed and that consent can be withdrawn at any time.

I give consent for X-rays to be taken today if required.

Females only: For X-ray purposes

Are you pregnant or likely to be pregnant? Yes No

If yes how many weeks? _____

Please sign_____

I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from the below named Chiropractor and any of the registered Chiropractors practicing at Lifetime Family Chiropractic Wellness Centres at Kenmore.

In the case of chiropractic services being rendered to a minor, or a patient who is recognised to have diminished intellectual capacity, this consent is to be signed by either a parent or legal guardian, this fact being appropriately noted below. I have read, or have had read to me the above consent and I have also had an opportunity to ask questions about this consent.

_____ Date: _____ Date:

Patient's Signature (Parent or Guardian) Chiropractor's Signature

_____ _____

Patient's Name (PRINTED) Date Chiropractor's Name (PRINTED) Date

LIFETIME WELLNESS

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